

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38001

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Anna Sharer

2. Date of Death

November 12, 1999

3. Time of Death

7:50 P. M.

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

219-14-8488

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 25, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

21 S. Mulberry Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5

College (1-4 or 5+)

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

domestic

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Edward Lawrence Kline

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Viola Kline

19a. Informant's Name/Relationship (Type, Print)

Connie J. Hasenbuhler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

sister 21 S. Mulberry Street Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rose Hill Cemetery

Date

11/16/99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac Street
Funeral Home Hagerstown, Maryland 2174023a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Cerebrovascular accident

Due to (or as a consequence of):

54 yrs.

b.

Pneumonia

Due to (or as a consequence of):

2 weeks

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28365

29d. Date signed (Month, Day, Year)

11-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANZAR J S H A P I 368 MILL STREET HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

NOV 15 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38002

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Frederick Smith

2. Date of Death
Month Day Year

November 12 1999

3. Time of Death
7:25 am

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

060-22-5541

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Aug. 15, 1928

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

10614 Harry Heth Road

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

XX Yes 2 No

If Yes, Give Year or Dates:

Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Radio Station

17. Father's Name (First, Middle, Last)

Frederick Smith

18. Mother's Name (First, Middle, Maiden Summe)

Victoria Pichur

19a. Informant's Name/Relationship (Type, Print)

Vanessa Smith/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1613 Loch Ness Road Towson, Maryland 21286

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

11-13-99 Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home, P.A.

425 S. Conococheague St. Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SQUAMOUS CELL CANCER of SCALP

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

NOV 12 1999

32. Registrar's Signature

B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

KENNETH SMITH November 12, 1999 7:25 a.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38003

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leo Fredlock Schenk

2. Date of Death
Month Day Year
November 12, 19993. Time of Death
9:10 PM

4a. Facility Name (If not institution, give street and number)

Cuppett-Weeks Nursing Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

212-12-8959

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 19, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4151 Sand Flat Road

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Farmer/Carpenter

16b. Kind of Business/Industry

Farming/Construction

17. Father's Name (First, Middle, Last)

Ambrose

Fredlock

Schenk

18. Mother's Name (First, Middle, Maiden Surname)

Lois

Paugh

19a. Informant's Name/Relationship (Type, Print)

Larry F. Schenk/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4151 Sand Flat Road, Oakland, Maryland 21550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

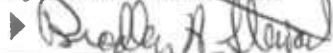
Omega Crematory

Date

11/15/99 Morgantown, WV

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Non-Hodgkins Lymphoma

7/99

Due to (or as a consequence of):

b. Diabete mellitus

yrs

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D30035

29d. Date signed (Month, Day, Year)

11/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Donald Richter, MD 1533 Memorial Drive, Oakland, Maryland 21550

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

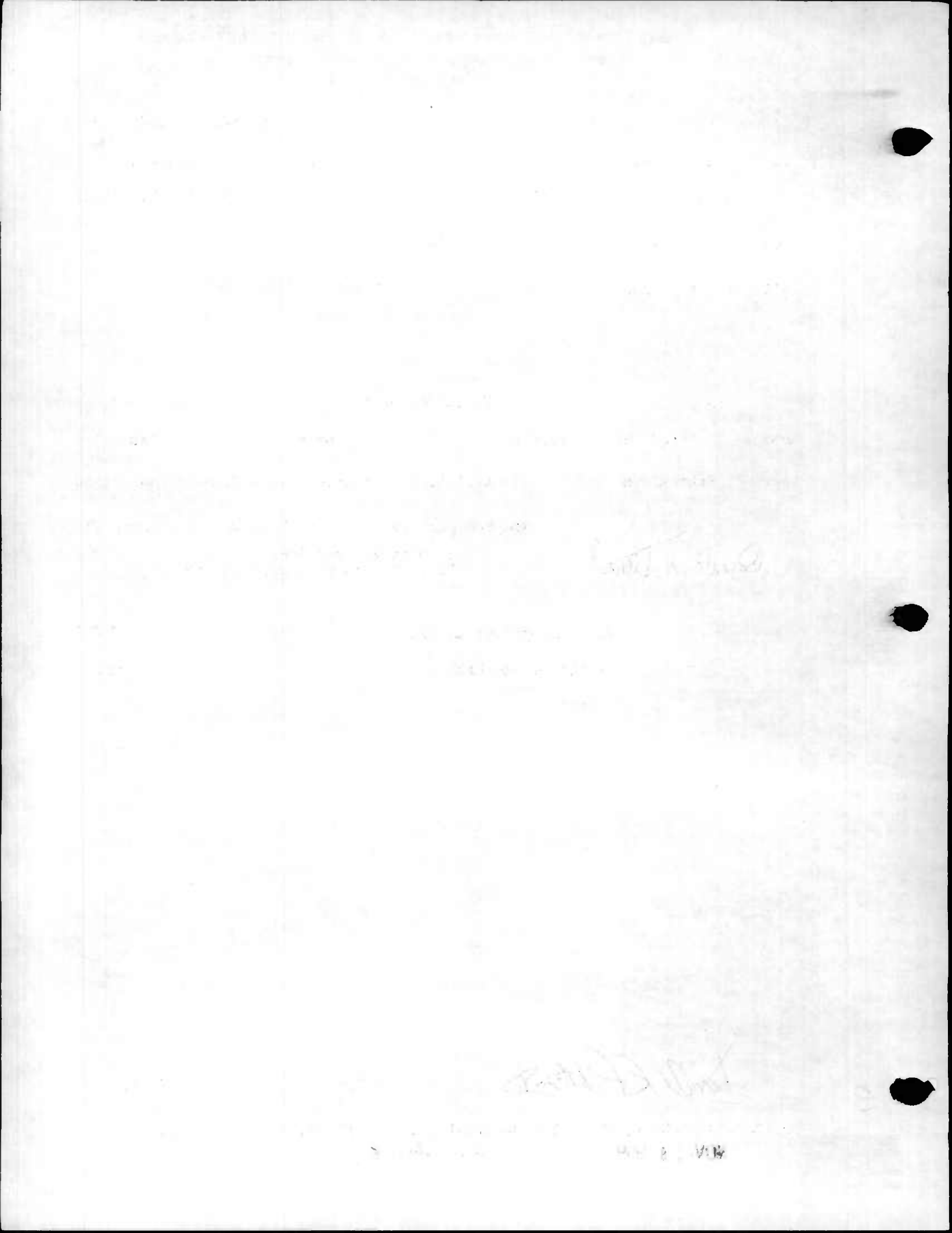
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38004

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELEANOR DELORES SHEALLY

2. Date of Death
Month Day Year
NOVEMBER 13, 19993. Time of Death
9:52 PM

4e. Facility Name (If not institution, give street and number)

110 A STREET, APT. 224

4b. City, Town, or Location of Death

MT. LAKE PARK

4c. County of Death

GARRETT

Funeral
Director

5. Social Security Number

213-30-5095

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV 27, 1931

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

MT. LAKE PARK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 A STREET, APT. 224

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

INSPECTOR

16b. Kind of Business/Industry

OPTICAL LENS PLANT

17. Father's Name (First, Middle, Last)

DANIEL LLOYD LOGSDON

18. Mother's Name (First, Middle, Maiden Summa)

MARY

BARRY

19a. Informant's Name/Relationship (Type, Print)

DONNA MULLAN - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

700 PENSINGER BLVD. MT. LAKE PARK, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROCKY GAP VET. CEMETERY

Date

11/17/99 CUMBERLAND, MD

21. Signature of Funeral Service Licensee

M00167

22. Name and Address of Facility

P.O. BOX 243
DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Laryngeal Tumor

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcoholic cirrhosis, Emphysema, Status post

resection A-V Malformation Cerebellum, Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D26650

29d. Date signed (Month, Day, Year)

11/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser MD PO Box 486 Oakland, MD 21550

31. Date filed (Month, Day, Year)

NOV 15 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

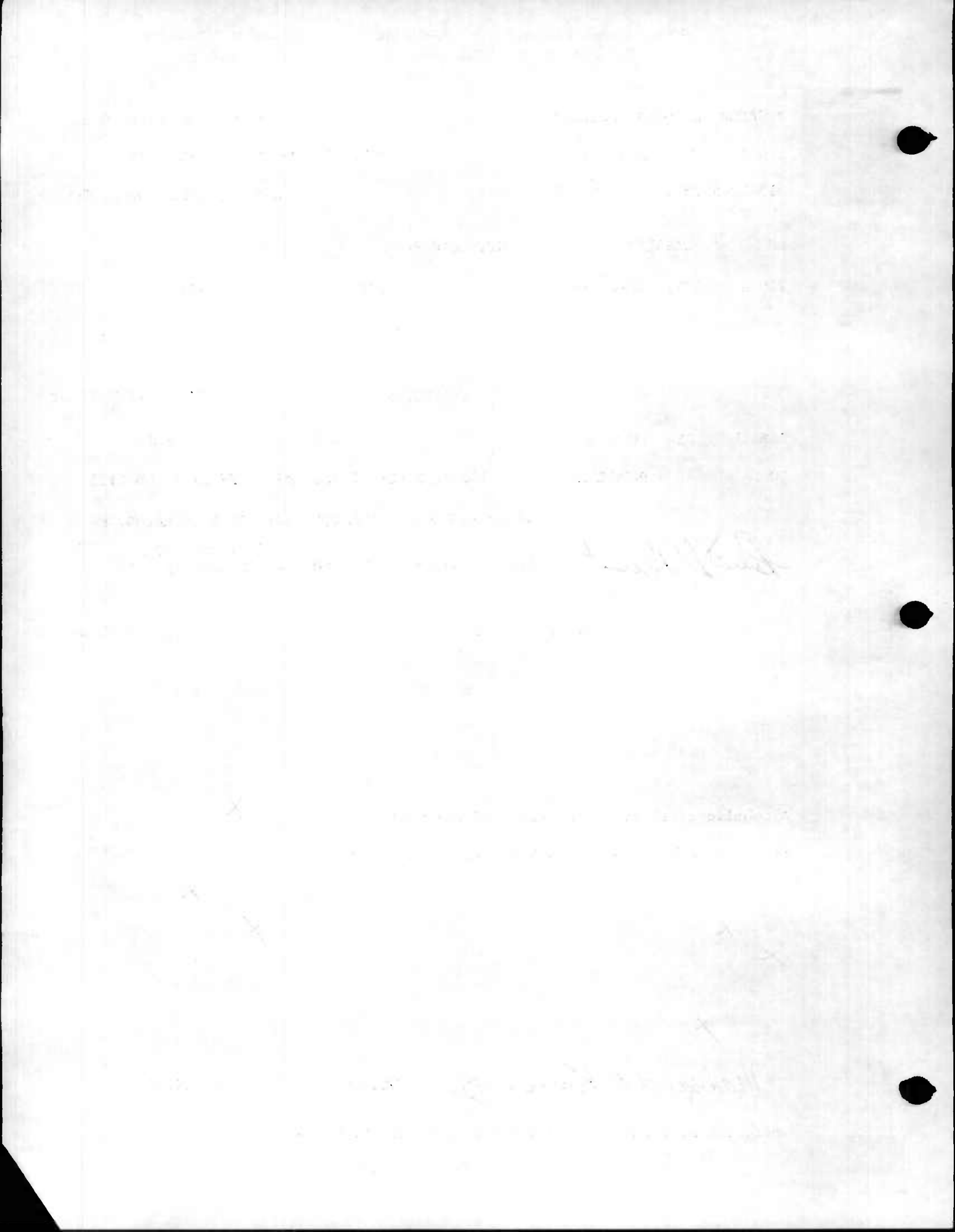
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38005

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Calvin Shingler

2. Date of Death

November 10, 1999

3. Time of Death

6:10 A.M.

4a. Facility Name (If not Institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

236-28-0131

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 25 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Allegany

10c. City, Town or Location

Westernport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21204 Creekside Dr.

10f. Zip Code

21562

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Coal Industry

17. Father's Name (First, Middle, Last)

George L. Shingler

18. Mother's Name (First, Middle, Maiden Surname)

Rosetta Trenum

19a. Informant's Name/Relationship (Type, Print)

Katherine Shingler wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21204 Creekside Dr. Westernport, Md. 21562

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac Memorial Gardens

Date

11-12-99

20c. Location - City or Town, State

Keyser, WV.

21. Signature of Funeral Service Licensee

F. Wayne Boal

22. Name and Address of Facility

Boal Funeral Home
111 Church St. Westernport, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. EXACERBATION OF CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LUNG CANCER WITH PREVIOUS PNEUMONECTOMY

PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Sagin

29c. License number

D35481

29d. Date signed (Month, Day, Year)

November 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mark Sagin, Memorial Hospital, Suite 400, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 15 1999

32. Registrar's Signature

S. Spotts

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JOHN SHINGLER 236-28-0131

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38006

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Wilson Teague

2. Date of Death
Month Day Year

Nov. 15, 1999

3. Time of Death
5:40 P.M.

4a. Facility Name (If not institution, give street and number)

1457 Harrow Avenue

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

442-40-0742

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 19, 1940

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1457 Harrow Avenue

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Computer maintenance

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Woodrow Wilson Teague

18. Mother's Name (First, Middle, Maiden Surname)

Bonnie Mae Stephenson

19a. Informant's Name/Relationship (Type, Print)

Carole M. Teague - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1457 Harrow Ave., Crofton, Md. 21114

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

11-20-99

20c. Location - City or Town, State

Oklahoma City, Okla.

21. Signature of Funeral Service Licensee

Shannon W. Beall - M00798

22. Name and Address of Facility

6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. amyotrophic lateral sclerosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Berez MD

29c. License number

00029571

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Berez MD 1655 Crofton Blvd suite 101, Crofton MD 21114

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Berez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15

Samuel A. Smith 1880 T. C. VON

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38007

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Amir Tabatabai

2. Date of Death
Month Day Year

Nov 15 1999 1915

3. Time of Death

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hosp

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-13-8153

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

7/24/1934

9. Birthplace (State or Foreign Country)

Iran

Usual Residence of Decedent

10a. State

VA

10b. County

Arlington

10c. City, Town or Location

Arlington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 N. Thomas St. Apt #2

10f. Zip Code

22203

10g. Citizen of What Country?

Iran

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Civil Service

16b. Kind of Business/Industry

Iranian Gov't.

17. Father's Name (First, Middle, Last)

Hossein

Tabatabai

18. Mother's Name (First, Middle, Maiden Surname)

Fatehtemh

Aghdas

19a. Informant's Name/Relationship (Type, Print)

Amir Hossein O. Tabatabai/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11061 Saffold Way Reston, VA 20190

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Mem. Park

Date

11/18/1999

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

Diana L. Lemo

22. Name and Address of Facility

National Funeral Home

7482 Lee Hwy Falls Church, VA 22042

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ASCVD

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

DME

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Diana L. Lemo

29c. License number

D00428

29d. Date signed (Month, Day, Year)

Nov 15, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TRA N BRECHER, MD OME

2101 Medical Park Dr
Silver Spring MD 20904

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

B. Lemo

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1954 7 2 1833
P. H. H. H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38008

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Garnet Thorpe

2. Date of Death

November 16, 1999 3:35 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctor's Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

579 20 9886

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs

Hours

Min.

8. Date of Birth

April 11, 1925

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5304 Shirley Drive

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

WWII

If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Budget Analyst

16b. Kind of Business/Industry

U.S. Dept of Commerce

17. Father's Name (First, Middle, Last)

Clarence Edward Thorpe

18. Mother's Name (First, Middle, Maiden Summa)

Byrdie Lesser

19a. Informant's Name/Relationship (Type, Print)

Bonnie Gatorian (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5304 Shirley Drive, Upper Marlboro, MD 20772

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

20c. Location - City or Town, State

Arlington Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Approximate Interval Between Onset and Death

Few weeks

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Coronary Atherosclerosis

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

status Post Tracheostomy.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ OOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 20108

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Rakesh Akora 14300 GALLANT FOX LN SUITE 222 BOVIE, MD 20715

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

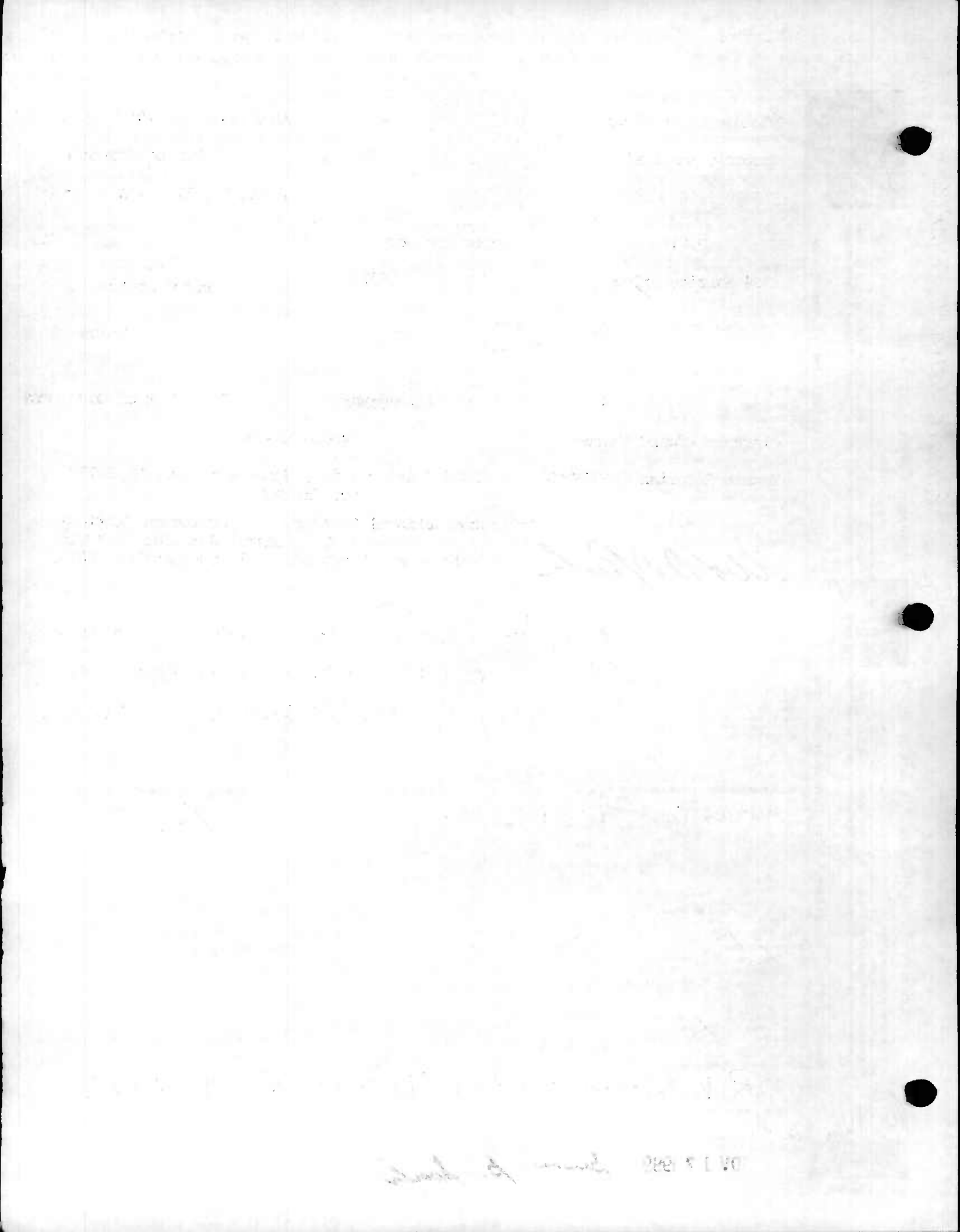
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Edward Garnet Thorpe



[Handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38009

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT M. TENG

2. Date of Death

November 11 1999

3. Time of Death

0245

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

059-34-4195

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

August 5, 1924

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10921 Inwood Avenue Apt. 426

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Unobtainable

18. Mother's Name (First, Middle, Maiden Surname)

Unobtainable

19a. Informant's Name/Relationship (Type, Print)

Michael Spencer/Stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12609 Two Farm Drive, Silver Spring, Md 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 11/17/99 Alexandria, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

Philip D. Rinaldi Funeral Service
11818 New Hampshire Ave Silver Spring, Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUBURBAN HOSPITAL

Due to (or as a consequence of):

b. LACERATION OF SCALP

Due to (or as a consequence of):

c. MOTOR VEHICLE ACCIDENT

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

November 8 1999

28b. Time of Injury

0816 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

HIT BY AUTO AS STEPPED OFF CURB.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UNIVERSITY PKWY & GABLE ST SILVER SPRING

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

mo. (One)

29c. License number

015236

29d. Date signed (Month, Day, Year)

November 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL MARSHALL, MD 1115 Rockville Pike, Rockville, MD 20852

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. B. B. B.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-368-6868.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

1911 11-20-1911

Handwritten signature or initials

1911 11-20-1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38010

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Emma Toney

2. Date of Death

November 1, 1999

3. Time of Death

1329

4a. Facility Name (If not Institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

220-32-6699

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 6, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Park Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

47761 Park Hall Road

10f. Zip Code

20667

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

William Gordon

18. Mother's Name (First, Middle, Maiden Sumame)

Nancy Barnes

19a. Informant's Name/Relationship (Type, Print)

Robert M. Toney, Jr./Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

47761 Park Hall Road, Park Hall, Maryland 20667

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. James Cemetery

Date

11/5/99

20c. Location - City or Town, State

St. James, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23a. Part 1. Enter the disease, or complications that caused the death:
shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Probable Myocardial Infarction

Sec.

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Signature and title of certifier

29c. License number

D14285

29d. Date signed (Month, Day, Year)

11-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyd, II, MD

Leonardtwn, Maryland 20650

State
Registrar

31. Date filed (Month, Day, Year)

NOV 03 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

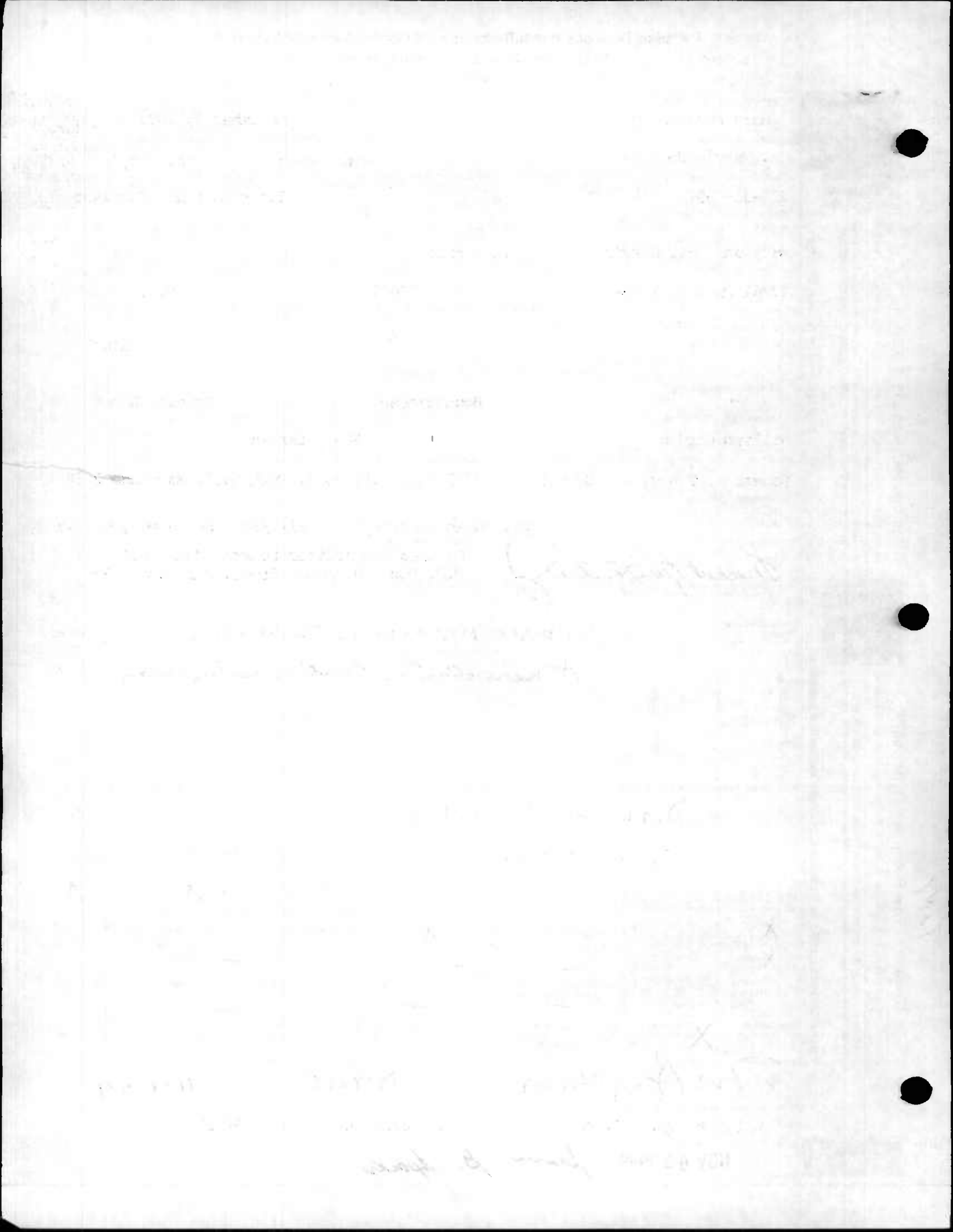
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38011

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Walter Thompson | | | | | 2. Date of Death Month Day Year November 10, 1999 | | | 3. Time of Death 5:30 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) 24790 Colton Point Road | | | | | 4b. City, Town, or Location of Death Clements | | | 4c. County of Death St. Mary's | |
| Funeral Director | 5. Social Security Number 214-36-4098 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) November 27, 1907 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County St. Mary's | | 10c. City, Town or Location Clements | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 24790 Colton Point Road | | | | 10f. Zip Code 20624 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) _____ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | | 16b. Kind of Business/Industry Agriculture | | |
| | 17. Father's Name (First, Middle, Last) Joseph Andrew Thompson | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Leona V. Marlow | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Walter J. Thompson, Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24730 Colton Point Road, Clements, Maryland 20624 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph's Cemetery | | Date 11-15-99 | | 20c. Location - City or Town, State Morganza, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr., M00052 | | | | | 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of 4th day Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of Certifier Leon Berube | | | | | 29c. License number D00506 | | | 29d. Date signed (Month, Day, Year) 11/15/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Berube, M.D., 28170 Old Village Rd., Mechanicsville, Maryland 20659 | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 16 1999 | | | | | 32. Registrar's Signature Benita B. Sparks | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38012

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

COLLEEN CAMP-VOELKER

2. Date of Death
Month Day Year

NOVEMBER 14, 1999

3. Time of Death

4:30 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8826 BALTIMORE STREET

4b. City, Town, or Location of Death

SAVAGE

4c. County of Death

HOWARD COUNTY

5. Social Security Number

212-54-3226

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 4, 1948

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD COUNTY

10c. City, Town or Location

SAVAGE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8826 BALTIMORE STREET

10f. Zip Code

20763

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

OFFICE MANAGER

16b. Kind of Business/Industry

COMMERCIAL DOOR COMPANY

17. Father's Name (First, Middle, Last)

THOMAS CAMP, SR.

18. Mother's Name (First, Middle, Maiden Surname)

REGINA O'LEARY

19a. Informant's Name/Relationship (Type, Print)

STEVEN VOELKER, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8826 BALTIMORE STREET, SAVAGE, MARYLAND 20763

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

11/17/99

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Shaw E. Wells

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Clement B. Knight

29c. License number

D41139

29d. Date signed (Month, Day, Year)

NOVEMBER 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLEMENT B. KNIGHT, M.D., 11065 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Knight

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
(Medical
Examiner)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38013

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Frits vanNorden | | | | 2. Date of Death Month Day Year November 12, 1999 | | 3. Time of Death 0700 | |
| | 4a. Facility Name (If not institution, give street and number) 11603 Pheasant Trail | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 216-38-0036 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 9, 1924 | |
| | 9. Birthplace (State or Foreign Country) Indonesia | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 11603 Pheasant Trail | | 10f. Zip Code 21742 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Asian | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanical engineer | | 16b. Kind of Business/Industry Pangborn Corp. | | 17. Father's Name (First, Middle, Last) Thomas vanNorden | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Johanna Elfrine Rosbak | | 19a. Informant's Name/Relationship (Type, Print) Mr. Archibald T. vanNorden/son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10809 Oak Forest Drive, Hagerstown, Maryland 21740 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery | | Data Nov. 16, 1999 | | 20c. Location - City or Town, State Hagerstown, Maryland | | 21. Signature of Funeral Service Licensee <i>Scott M. Munnich</i> | |
| | 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Encephalopathy - metabolic and traumatic</u> 2 yrs Due to (or as a consequence of): b. <u>Atherosclerotic cardiovascular disease</u> 20 yrs. Due to (or as a consequence of): c. <u>Subdural Hematomas</u> 2 yrs Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>George C. Newman, II, PH.D.M.D.</i> | | 29c. License number D17591 | | 29d. Date signed (Month, Day, Year) 11/15/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE C. NEWMAN, II 11110 MEDICAL CAMPUS RD. ST. 130, HAG. MD | | 31. Date filed (Month, Day, Year) NOV 16 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | 33. Date of Death NOV 12 1999 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38014

| | | | | | | | | | | |
|---|---|--|---|--|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MILDRED EDITH VETTER | | | | | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | 3. Time of Death 11:07 AM | |
| | 4a. Facility Name (If not institution, give street and number) 213 W. CENTER STREET | | | | | | 4b. City, Town, or Location of Death OAKLAND | | 4c. County of Death GARRETT | |
| Funeral Director | 5. Social Security Number 236-36-1586 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) MARCH 20, 1917 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County GARRETT | | 10c. City, Town or Location OAKLAND | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 213 W. CENTER STREET | | | | 10f. Zip Code 21550 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) GILBERT HOWARD ROBINETTE | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MYRTLE NAOMI GROVE | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MARY LOU STEMPLE - DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 PALMER LANE OAKLAND, MARYLAND 21550 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARRETT MEMORIAL GARDENS | | Date 11/20/99 | | 20c. Location - City or Town, State OAKLAND, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee  | | M00167 | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 | | | | | |
| Physician /Medical Examiner | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC DISEASE DUE TO CARCINOMA OF BREASTS 2 1/2 YEARS Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Due to (or as a consequence of): c. CONGESTIVE HEART FAILURE WEEKS Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D07258 | | 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANDREW E. MANCE, M.D. 3 S. THIRD ST. OAKLAND, MD 21550 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38015

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy W Waters

2. Date of Death

November 9, 1999

3. Time of Death

9:20 P.M.

4a. Facility Name (If not institution, give street and number)

Casey House Hospice

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-01-4779

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 21, 1912

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland Prince Georges

10b. County

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10511 Meadowlake Terrace

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Esau Brown

18. Mother's Name (First, Middle, Maiden Surname)

Julienne Ford

19a. Informant's Name/Relationship (Type, Print)

Edwin Martin/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10511 Meadowlake Terr. Mitchellville, MD 20721

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery Nov. 15, 1999 Brentwood, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ft. Lincoln Funeral Home
3401 Bladensburg Rd. Brentwood, MD 20772

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Carcinoma

Approximate Interval Between Onset and Death

8 Months

a.

Due to (or as a consequence of):

Colon Cancer

1 year

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] E. P. Libre MD

29c. License number

D)9470

29d. Date signed (Month, Day, Year)

November 10, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Eugene P. Libre, M.D. 10400 Connecticut Ave. Kensington, Md 20895

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

[Signature] B. Apali

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

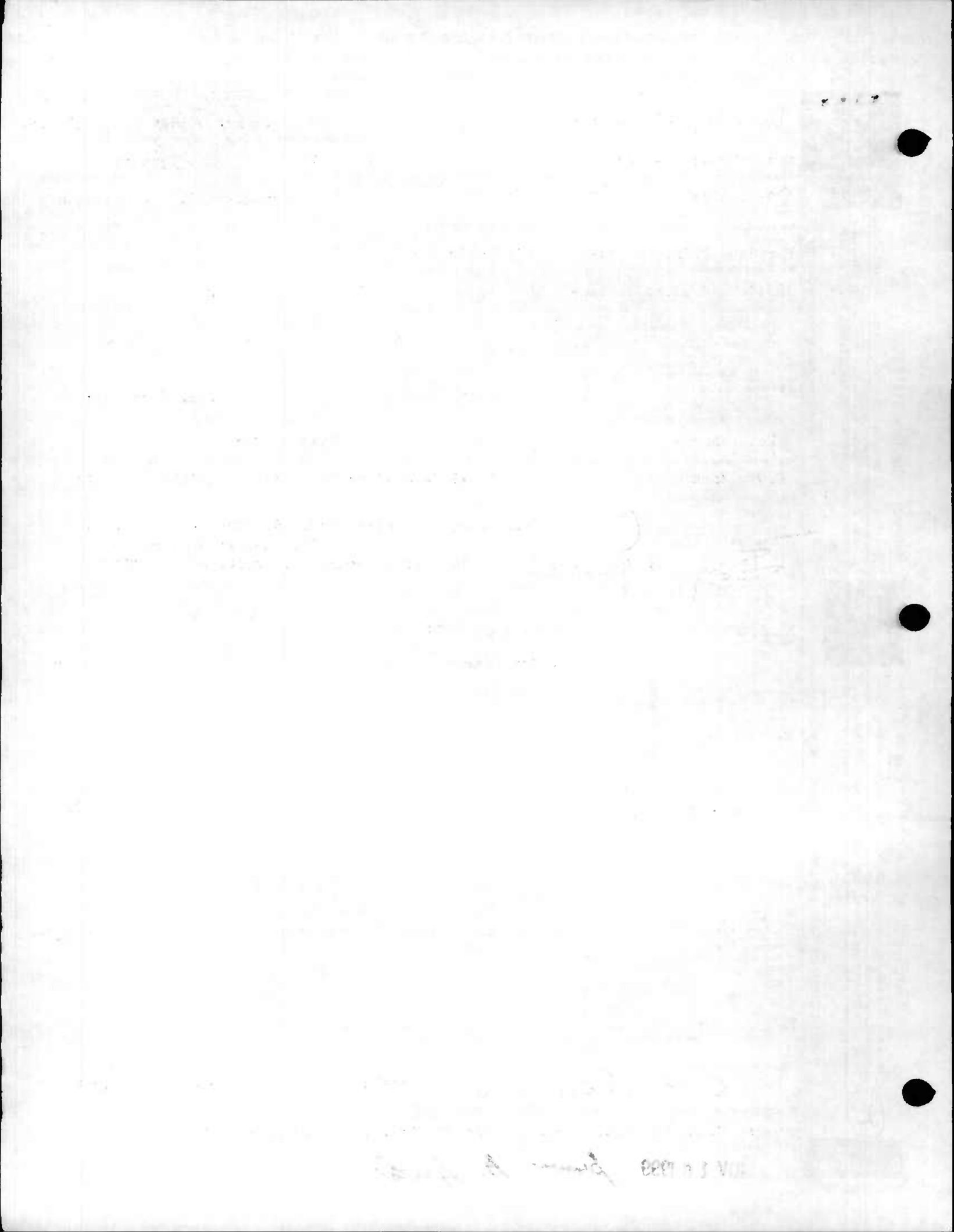
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.


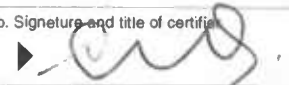
99 38016

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) James R. Waeldner | | | | 2. Date of Death Month November Day 16 , Year 1999 | | | | 3. Time of Death 1:52 pm | |
| 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | | | 4c. County of Death Montgomery | |
| 5. Social Security Number 181-36-0835 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 16, 1945 | | 9. Birthplace (State or Foreign Country) New Jersey | |
| Usual Residence of Decedent | | | | | | | | | |
| 10e. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Beltsville | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 11222 Cherry Hill Road, #204 | | | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: VIETNAM | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paralegal | | | | 16b. Kind of Business/Industry Federal Government | |
| 17. Father's Name (First, Middle, Last) William J. Waeldner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Adele Burch | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Elizabeth Waeldner - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11222 Cherry Hill Road, #204, Beltsville, MD 20705 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery | | Date 11/22/99 | | 20c. Location - City or Town, State Cheltenham, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Due to (or as a consequence of): b. Hard and Neck Cancer Due to (or as a consequence of): c. 11 months Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number MD 0A1715 | | 29d. Date signed (Month, Day, Year) 11.17.99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHITRA K. NARAYANAN MD GREENBELT MD 20770 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | | 32. Registrar's Signature  | | | | | |

Handwritten signature and date: 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38017

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

VIVIAN B. WATSON

2. Date of Death
Month Day Year
November 8, 19993. Time of Death
10:15 PM

4a. Facility Name (If not Institution, give street and number)

Mariner Health Center At Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

479-03-6154

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 27, 1919

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

D.C.

10b. County

Washington

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3018 26th Street, N.E.

10f. Zip Code

20018

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: American Indian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

+02

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Charles Baker

18. Mother's Name (First, Middle, Maiden Surname)

Josephine DeGroat

19a. Informant's Name/Relationship (Type, Print)

Carrel Watson, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3018 26th St., N.E. Wash., DC 20018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lincoln Memorial Cemetery 11/13/99 Suitland, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

W. G. Joffe

22. Name and Address of Facility

Frazier's Funeral Home, Inc.

389 R.I. Ave., NW Wash., DC 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic rectal cancer

Due to (or as a consequence of):

b. Cholecystitis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

W. G. Joffe

29c. License number

000053524

29d. Date signed (Month, Day, Year)

November 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2309 Shore Guelde Beach Carhart, MD 20902

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NOV 1 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38018

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Watts

2. Date of Death

November 12 1999

3. Time of Death

4:35pm

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

244-58-5723

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 19, 1940

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Glendale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12207 Guineyere Road

10f. Zip Code

20769

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John A. Watts

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Govan

19a. Informant's Name/Relationship (Type, Print)

Jacquelyn R. Watts/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12207 Guineyere Rd., Glendale, MD 20769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Cemetery

Date

11/18/99

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Belva A. Fenty

22. Name and Address of Facility

Johnson & Jenkins Funeral Home
716 Kennedy St., NW, Washington, DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Morris Jutovich

29c. License number

D31089

29d. Date signed (Month, Day, Year)

November 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORRIS JUTOVICH, MD 8201 CORPORATE DRIVE, SUITE 620 LANDOVER, MD 20785

State
Registrar

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

Belva A. Fenty

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38019

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JOSEPH LEE WILLS | | | | 2. Date of Death Month Day Year NOV. 09, 1999 | | | | 3. Time of Death 3:27 PM | | | | | |
| 4a. Facility Name (If not institution, give street and number) GLADYS SPELLMAN NURSING CENTER | | | | | | 4b. City, Town, or Location of Death CHEVERLY | | | | 4c. County of Death PRINCE GEORGES | | | |
| 5. Social Security Number 212-18-2272 | | | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) July 9, 1922 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State N/A | | | 10b. County N/A | | | 10c. City, Town or Location WASHINGTON, D.C. | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 1727 CAPITOL AVE. N.E. #1 | | | | | | 10f. Zip Code 20002 | | | | 10g. Citizen of What Country? UNITED STATES | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH College (1-4 or 5+) : | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) METRO CONSTRUCTION | | | | 16b. Kind of Business/Industry Private | | | |
| 17. Father's Name (First, Middle, Last) WINFIELD WILLS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) AGNES WILLS | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARGARET WILLS/WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 CAPITOL AVE. N.E., #1 WASHINGTON, D.C. 20002 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WASHINGTON NATIONAL CEM. | | | | Date NOV. 16, 1999 | | 20c. Location - City or Town, State SUITLAND, MD | | | |
| 21. Signature of Funeral Service Licensed <i>Edward M. Dudley</i> EDWARD M. DUDLEY | | | | | | 22. Name and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Congestive Heart Failure</i> Due to (or as a consequence of): b. <i>Respiratory Failure on mechanical ventilation</i> Due to (or as a consequence of): c. <i>Recurrent Colon Cancer</i> Due to (or as a consequence of): d. <i>H/O Atrial fibrillation</i> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>H/O Liver resection for metastasis</i> <i>Hypertension</i> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>Nancy Kalpana Timothy</i> | | | | 29c. License number D0052848 | | 29d. Date signed (Month, Day, Year) 11/10/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY K TIMOTHY 5807 ANNAPOLIS RD, HYATTSVILLE, MD - 20784 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 15 1999 | | | | 32. Registrar's Signature <i>B. Apau</i> | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0058.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

4

State
Registrar

Handwritten signature or scribble.

NOVA 2 1 VON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38020

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Estelle Marie Wallace | | | | | | 2. Date of Death Month Day Year November 1, 1999 | | 3. Time of Death 10:40 AM | |
| | 4a. Facility Name (If not Institution, give street and number) 24599 Clarkes Landing Lane | | | | | | 4b. City, Town, or Location of Death Hollywood | | 4c. County of Death St. Mary's | |
| Funeral Director | 5. Social Security Number 578-18-2443 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) November 5, 1915 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County St. Mary's | | 10c. City, Town or Location Hollywood | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 24599 Clarkes Landing Lane | | | | | | 10f. Zip Code 20636 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) 7th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Richard Olliva DeVaughn | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Geneva Ridgeway | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Diane M. Bean/ Friend | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24591 Phil's Lane, Hollywood, Maryland 20636 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens | | Date 11/4/99 | | 20c. Location - City or Town, State Leonardtown, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>Michael J. Gardiner</i> | | | | | | 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. box 270, Leonardtown, Maryland 20650 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Respiratory Failure Due to (or as a consequence of): b. Sepsis - CORD + Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Approximate Interval Between Onset and Death ~ 48 hrs | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>K. Mehta</i> | | | | 29c. License number D36200 | | 29d. Date signed (Month, Day, Year) 11/02/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Kiran Mehta Philip J. Bean Med. Ctr. Hollywood, Md 20636 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 03 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Wm. D. Vow

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38021

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marquerite L. Wilbar

2. Date of Death
Month Day Year

10 30 99

3. Time of Death

1519

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

578-32-4720

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7/16/25

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

California

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24131 North Patuxent Beach Drive

10f. Zip Code

20619

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Architecture

17. Father's Name (First, Middle, Last)

Thomas A. Merrell

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Jane Murphy

19a. Informant's Name/Relationship (Type, Print)

James L. Wilbar, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24131 N. Patuxent Beach Dr., California, MD 20619

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

11-3-99

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M0052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Rd., Leonardtown, MD 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral infarct

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical ExaminerCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. B. B. M.D.

29c. License number

A04178435H10011

29d. Date signed (Month, Day, Year)

10/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

University of Maryland Medical Center 21 S. Greene St Baltimore, MD.

State
Registrar

31. Date filed (Month, Day, Year)

NOV 03 1999

32. Registrar's Signature

B. B. B.

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38022

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Adelaide Wise

2. Date of Death

NOVEMBER 10 1999

3. Time of Death

1:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

220-32-7225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jul. 23, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Leonardtown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23834 Point Lookout Road

10f. Zip Code

20650

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

John Walter Whitbeck

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Marie Clouse

19a. Informant's Name/Relationship (Type, Print)

Mary E. Beaver - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 12, Clements, Maryland 20624

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Our Lady's Church Cemetery 11-13-99 Leonardtown, MD

21. Signature of Funeral Service Licensee

Michael K. Blankenship, M00857

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.
22955 Hollywood Rd., Leonardtown, MD 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory failure

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Cerebrovascular accident

1 day

End stage COPD

long time

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip J. Bean

29c. License number

D 47066

29d. Date signed (Month, Day, Year)

11-15-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AVANI D. SHAH M.D.

PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636

State
Registrar

31. Date filed (Month, Day, Year)

NOV 15 1999

32. Registrar's Signature

Benita B. Spink

Baltimore, Maryland 21215-0020

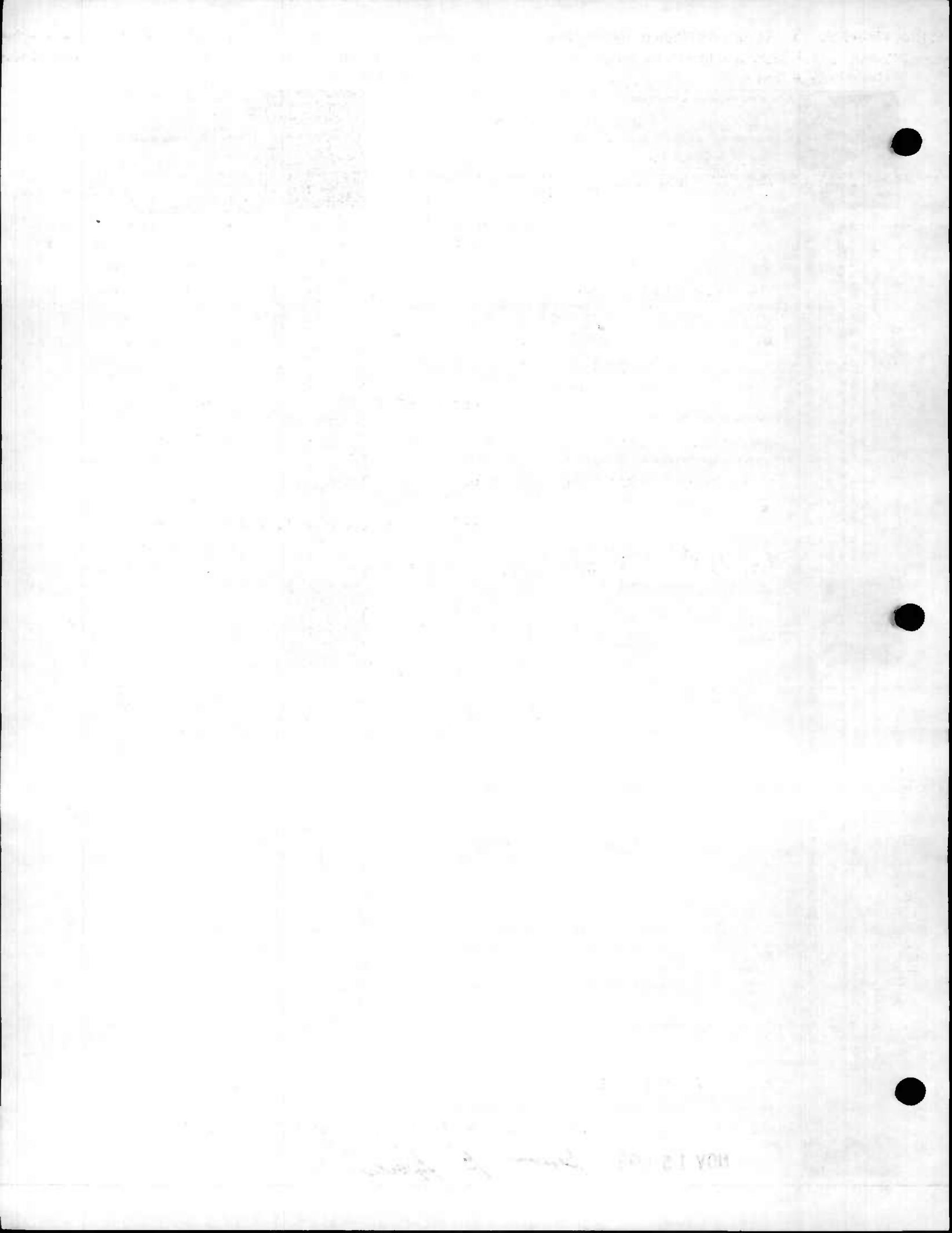
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RUTH WISE
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38023

| | | | | | | | | | | | |
|---|--|---|---|---------------------------------|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nelson Lee WARD, Jr. | | | | | | 2. Date of Death Month Day Year November 23 1999 | | 3. Time of Death 06:46 | | |
| | 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | | |
| Funeral Director | 5. Social Security Number 218-40-3546 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) March 24, 1941 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Clear Spring | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 14520 National Pike | | | | 10f. Zip Code 21722 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1959-63 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) paint shop worker | | | 16b. Kind of Business/Industry auto parts distribution center | | | |
| | 17. Father's Name (First, Middle, Last) Nelson Lee Ward | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Teresa Catherine McKeown | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Linda Ward - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14520 National Pike, Clear Spring, Md. 21722 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery | | Date 11-26-99 | | 20c. Location - City or Town, State Clear Spring, Md. | | | | |
| | 21. Signature of Funeral Service Licensee <i>Scott Munnich</i> | | | | 22. Name and Address of Facility MINNICH FUNERAL HOME 15 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>acute pancreatitis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 3 days |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension & Diabetes</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>H. Munnich</i> | | 29c. License number DC011264 | | 29d. Date signed (Month, Day, Year) Nov 23 99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>H. Munnich MD 580 Northtown Hagerstown, MD</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38024

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Shenk Wills

2. Date of Death

Month Day Year
NOV 17 1999

3. Time of Death

5:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Fahrney-Keedy Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

5. Social Security Number

219-36-3733

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 30, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

149 Summit Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Charles Edward Shenk

18. Mother's Name (First, Middle, Maiden Surname)

Maud L. Barkdoll

19a. Informant's Name/Relationship (Type, Print)

Harold E. Wills

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

149 Summit Avenue Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rose Hill Cemetery

Date

11/20/99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich
Funeral Home

305 N. Potomac Street

Hagerstown, Maryland 21740

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

b.

HYPERTENSION

Due to (or as a consequence of):

c.

Aortic Stenosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5:45 AM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Vasant Datta

29c. License number

D 52323

29d. Date signed (Month, Day, Year)

11/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vasant Datta 334 Mill Street Hagerstown, Maryland 21740

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

N. Sparks

State
Registrar

Virginia Shenk Wills 11/17/99 5:45 PM

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38025

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph William Webb

2. Date of Death

November 16, 1999

3. Time of Death

11:40 AM

4a. Facility Name (If not institution, give street and number)

Coffman Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral
Director

5. Social Security Number

214-16-0206

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 25, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington Co.

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13522 Paradise Drive

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Laborer

16b. Kind of Business/Industry

Aircraft Manufacturing

17. Father's Name (First, Middle, Last)

John William Webb, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna May Swope

19a. Informant's Name/Relationship (Type, Print)

JoEleanor Webb/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13603 Paradise Drive, Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

Nov. 19

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

► Kelly Q. Zimmerman

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Emphysema

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

70 years
1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Deerhills virus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Samuel Chan, MD

29c. License number

D36655

29d. Date signed (Month, Day, Year)

Nov. 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1185 MI. AETNA RD; Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

► [Signature] B. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38026

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Franklin Wade

2. Date of Death
Month Day Year

November 13 1999 10:15 Am

3. Time of Death

Funeral
Director

4e. Facility Name (If not Institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-42-7227

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 25, 1944 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

427 Guilford Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Monumental Insurance

17. Father's Name (First, Middle, Last)

Edgar Franklin Wade

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Sowers

19a. Informant's Name/Relationship (Type, Print)

Mary O. Wade Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

427 Guilford Avenue Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul's Cemetery

Date

11/16/99

20c. Location - City or Town, State

Western Pike Hagerstown, Md.

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac Street
Funeral Home Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Carcinoma of pancreas*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frederic H. Gass

29c. License number

D23623

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederic H. Gass MD 11110 medical Campus Rd Hagerstown Md

State
Registrar

31. Date filed (Month, Day, Year)

NOV 15 1999

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38027

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Eaton Wommack

2. Date of Death

November 11, 1999

3. Time of Death

12:50 P.M.

4a. Facility Name (If not Institution, give street and number)

Williamsport Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

459-07-6096

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 28, 1915

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

WV

10b. County

Jefferson

10c. City, Town or Location

Shepherdstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1001 Sallie Lane

10f. Zip Code

25443

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John Harrison Eaton Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Martha Ann Forquer

19a. Informant's Name/Relationship (Type, Print)

John H. Eaton (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1 Box 164 Shepherdstown, WV 25443

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Nov. 16, 1999 Smithsburg, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kenneth R. Davis

22. Name and Address of Facility

Davis Funeral Home
12525 Bradbury Ave.
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ted Howe

29c. License number

D33700

29d. Date signed (Month, Day, Year)

November 16, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TED HOWE 7542 OVERLOOK DR. BOWSBORO, MD 21713

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38028

Whitbeck, Betty Florence
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) BETTY FLORENCE WHITBECK | | | | | | 2. Date of Death Month November Day 16 Year 1999 | | 3. Time of Death 11:04 PM | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| 5. Social Security Number 577-44-6487 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) November 15, 1934 | | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 55 East Washington Street | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own home | | |
| 17. Father's Name (First, Middle, Last) Les Alan Guessford | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Frances Purdham | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ezra Glenn Jr, Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 East Washington Street, Hagerstown, Md. 21740 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Beautiful View Cemetery | | Date 11-15-99 | | 20c. Location - City or Town, State Middleburg, Maryland | |
| 21. Signature of Funeral Service Licensee R. Noel Brady | | | | 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE AIRWAY DISEASE Due to (or as a consequence of): d. MULTIPLE MYELOMA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Approximate Interval Between Onset and Death a. 2 DAYS b. 2 DAYS c. 5 YRS. d. 2 YRS. | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier Manjiv G. Kapur | | | | 29c. License number D28365 | | 29d. Date signed (Month, Day, Year) 11-11-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZAR J SHARMA 368 MILL STREET HAGERSTOWN MD 21740 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 12 1999 | | | | 32. Registrar's Signature G. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended
Lines 8. & 12.
11-16-99 SC WCHD

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38029

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DONARD

2. Date of Death
Month Day Year

November 10 1999

3. Time of Death

11:30 pm

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-72-7539

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
APR. 4, 1957/1958

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

WV

10b. County

BERKELEY

10c. City, Town or Location

HEDGESVILLE

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

RT. 1, BOX 189

10f. Zip Code

25427

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

BRAKE PRESSER

16b. Kind of Business/Industry

DIXIE NARCO

17. Father's Name (First, Middle, Last)

DONARD L. WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

JOSIE NEWBERRY

19a. Informant's Name/Relationship (Type, Print)

DONARD L. WILLIAMS/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

830 SHAMROCK DRIVE, SEBRING, FL 33872

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ROSEDALE CEMETERY

Date

11/13/99

20c. Location - City or Town, State

MARTINSBURG, WV

21. Signature of Funeral Service Licensee

Charles W. Brown

22. Name and Address of Facility

BROWN FUNERAL HOME, 327 W. KING ST.
PO BOX 821, MARTINSBURG, WV 2540223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

24-48 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Myocardial infarction
Due to (or as a consequence of):

12 hrs

c. Bowel infarction
Due to (or as a consequence of):

12 hrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial infarction, Aortic Valve Repair 1995,

CVA X 2, HTN

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

80 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury28c. Injury at
Work?

10 Yes 20 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joseph C. Moran

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 10, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph C. Moran Johns Hopkins Hospital 600 N. Wolfe St. Baltimore MD

31. Date filed (Month, Day, Year)

NOV 16 1999

32. Registrar's Signature

B. Sparks

21287

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38030

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Derrick A. Young

2. Date of Death

November 13, 1999

3. Time of Death

9:40pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

578-94-0243

8. Sex

10 M 20 F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 5, 1960

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

8709 Deborah St.

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mail Room Supervisor

16b. Kind of Business/Industry

SRA- Corporation

17. Father's Name (First, Middle, Last)

Adolphus R. Young

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Banks

19a. Informant's Name/Relationship (Type, Print)

Adolphus R. Young/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8709 Deborah St. Clinton, Maryland 20735

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

11/19/99 Clinton, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Keith A. Jones

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Malignant Lymphoma

Due to (or as a consequence of):

b. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

28. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 80 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
investigation
20 Accident 60 Could not be
determined
30 Suicide 40 Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harry J. Jones

29c. License number

D20352

29d. Date signed (Month, Day, Year)

11-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry J. Jones MD 8926 Woodmont Rd Clinton, MD

31. Date filed (Month, Day, Year)

NOV 17 1999

32. Registrar's Signature

Barbara B. Jones

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
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any injury or other traumatic event, the Medical Examiner must be notified at
202-691-1000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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[Handwritten signature or initials.]

NOV 12 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38032

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Alexander Zienda

2. Date of Death

Month

Day

Year

NOVEMBER 27 1999

3. Time of Death

01:58PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

5. Social Security Number

167-24-0359

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 7, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

46630 Yorktowne Road

10f. Zip Code

20653

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Chef Instructor

16b. Kind of Business/Industry

Seamanship School

17. Father's Name (First, Middle, Last)

Anthony

Zienda

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Zienda

19a. Informant's Name/Relationship (Type, Print)

Doris Margaret Zienda (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

46630 Yorktowne Road, Lexington Park, Maryland 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Memorial Gardens

Date

12/1/1999

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Michael Kevin Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Probable Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sec

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

YRS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

—

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

—

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

—

28f. Location (Street and Number or Rural Route Number, City or Town, State)

—

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William D. Boyd, II

29c. License number

1214285

29d. Date signed (Month, Day, Year)

11-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd, II, MD

Leonardtwn, Maryland 20650

31. Date filed (Month, Day, Year)

NOV 30 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

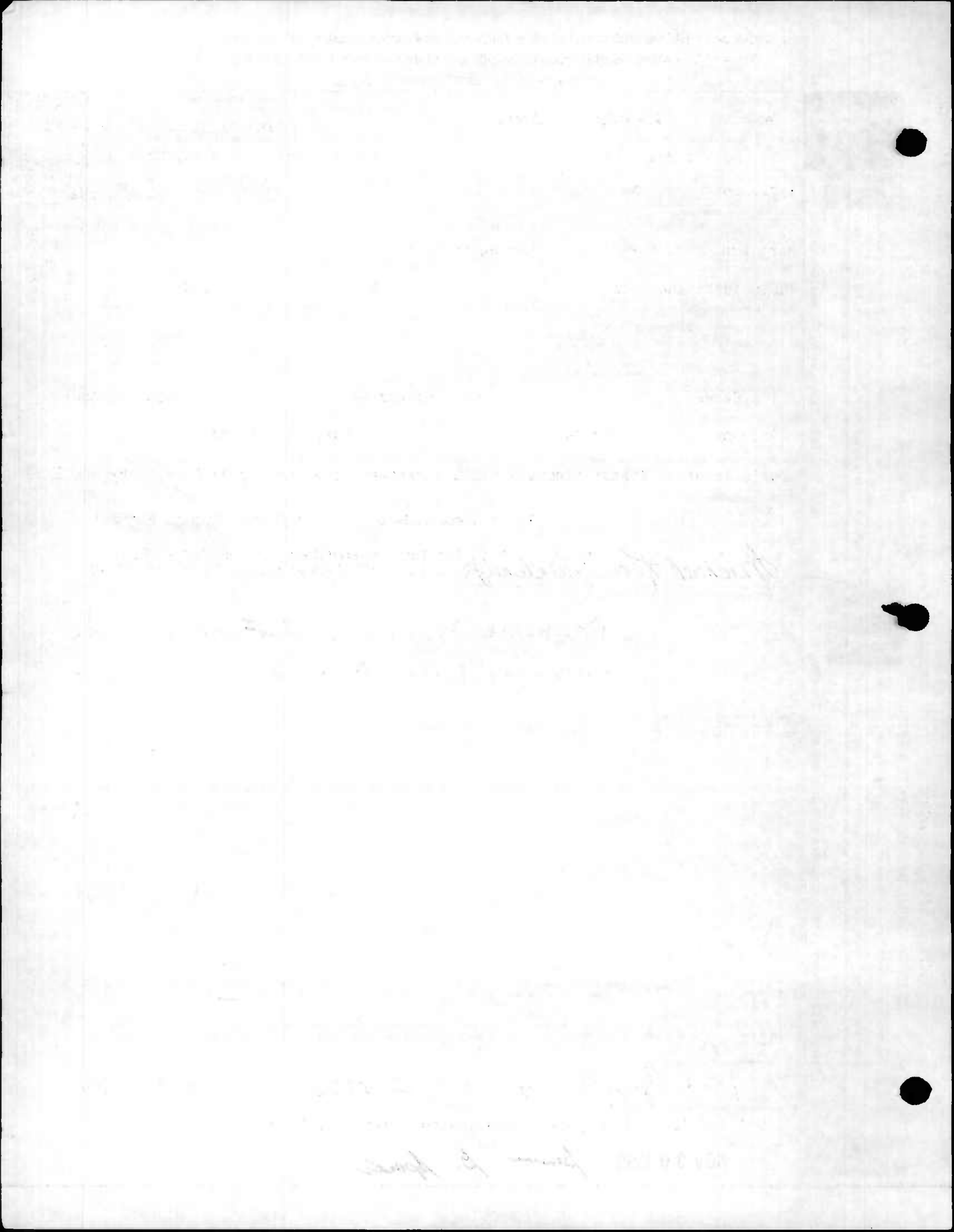
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JOSEPH ALEXANDER ZIENDA

Division of Vital Records, P.O. Box 68760,



B.K.S
PHILLIP AYE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38033

| | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Phillip Jerrell Aye | | | | | 2. Date of Death Month Day Year NOV. 28, 1999 | | 3. Time of Death 1949 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL E.R. | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | |
| Funeral Director | 5. Social Security Number 220-02-2855 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 17 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 10-1981 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 10e. Street and Number 3000 Presbury Street | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | |
| To Be Completed by Physician/Medical Examiner | 16b. Kind of Business/Industry High School | | | | | 17. Father's Name (First, Middle, Last) Phillip C. Aye | | 18. Mother's Name (First, Middle, Maiden Surname) Marie Moten | | 19e. Informant's Name/Relationship (Type, Print) Phillip/Marie Aye-Parents | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Presbury Street, Balto./Md. 21216 | | | | | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Nat'l Park | | 20c. Location - City or Town, State 12-4-99 Laurel, Maryland | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Lewis T. Gwynn | | | | | 22. Name and Address of Facility Lewis T. Gwynn Funeral Home 4517 Parkheights Ave. Balto. Md. 21215-6393 | | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Asthma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | 29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier Barbara L. ... | | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 29, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Case, MD 111 Penn Street, Baltimore, Maryland 21201 | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | | 32. Registrar's Signature Benjamin K. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DEC 6 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38034

| | | | | | | | | | | |
|---|---|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HATTIE R. AARONSON | | | | 2. Date of Death Month NOV. Day 26 Year 1999 | | | | 3. Time of Death 7:45PM | |
| | 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT & NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 213-32-9647 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/27/1904 | | 9. Birthplace (State or Foreign Country) MD. | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 7920 SCOTTS LEVEL ROAD | | | | 10f. Zip Code 21208 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS | | | | 16b. Kind of Business/Industry GARMENT | | | | 17. Father's Name (First, Middle, Last) JACOB COHEN | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) LENA ZELDITZ | | | | 19a. Informant's Name/Relationship (Type, Print) LOIS COHN / DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 HUNT DRIVE - BALTIMORE, MD 21209 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) (ANSHE EMUNAH) AITZ CHAIM | | | | 20c. Location - City or Town, State 11/29/99 BALTIMORE, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Scott M. Gittler</i> | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Congestive Heart Failure Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) 11/27/99 | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>On Passon M.D.</i> | | | | 29c. License number D 42561 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) 11/27/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Passon, M.D. 21 Crossroads Dr. #400 Owings Mills, MD 21117 | | | | 31. Date filed (Month, Day, Year) DEC 06 1999 | |
| | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | 33. State Registrar DEC 06 1999 | | | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | |

ORIGINAL

DEC 02 1960

ADH
BOBBY BETTS
99-7099-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

99 38035

| | | | | | | | | | | |
|---|---|---|---------------------------------|---|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BOBBY BETTS | | | | 2. Date of Death Month NOVEMBER Day 27 , Year 1999 | | | | 3. Time of Death 2155 PM | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220 86 1855 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 39 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 20, 1960 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 Yes 2 No | | | |
| 10e. Street and Number 2527 OSWEGO AVE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | | | | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker | | 16b. Kind of Business/Industry Private Business | | | | | | |
| 17. Father's Name (First, Middle, Last) James Betts | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Townes | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frances Townes / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2527 OSWEGO AVE BALTIMORE MD 21215 | | | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | Date 12/5/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Gray Harris | | 22. Name and Address of Facility CRATHAN HOMES & N. 5240 RAISTOWN RD BALTIMORE MD 21215 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Stabs & Cutting Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? XXX Yes 2 No | | Hospital: 1 Inpatient 2 ER/Outpatient XXX Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 26. Place of Death (Check only one) | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) 11-27-99 | | 28b. Time of Injury 2055M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred subject skinned | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4000 Park Heights Ave | | | | | | |
| 29a. Certifier (Check only one) XXX Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOVEMBER 28, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38036

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert James Brown | | | | 2. Date of Death Month Day Year DEC 5, 1999 | | 3. Time of Death 2:00pm | |
| | 4a. Facility Name (If not institution, give street and number) 211 Mt. Holly Street | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-18-9183 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR 15, 1924 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 211 Mt. Holly Street | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor | | 16b. Kind of Business/Industry Janitorial Service | | | | |
| 17. Father's Name (First, Middle, Last) Frederick Brown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Savilla Smith | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Veronica Wright/niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6132 Greenmeadow Pkwy Baltimore, MD 21209 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Date 12/6/99 | | 20d. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stage IV Non Hodgkins Lymphoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Janet Cooper MD | | 29c. License number D46118 | | 29d. Date signed (Month, Day, Year) 12/6/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janet COOPER MD 1447 York RD Lutherville MD 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-1234.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38037

| | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|---|--|--|--|---|---|----|---------------|---|----|--|----|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VILLER | | | | 2. Date of Death Month Day Year DECEMBER 2 1999 | | | | 3. Time of Death 5:52 PM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 215 12 1237 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) 04/23/1923 | | 9. Birthplace (State or Foreign Country) VA | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number 1816 PENROSE AVE. | | | | 10f. Zip Code 21223 | | | | 10g. Citizen of What Country? USA | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) CRANE OPERATOR | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BETHLEHEM STEEL | | | | 16b. Kind of Business/Industry | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) JUNIOUS BROWN | | | | 18. Mother's Name (First, Middle, Maiden Surname) HALLIE COLEMAN | | | | | | | | | | | | | | | |
| 19e. Informant's Name/Relationship (Type, Print) ESTHER BROWN /WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 PENROSE AVE BALTO., MD. 21223 | | | | | | | | | | | | | | | |
| 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD. NATIONAL MEM PARK | | 20c. Location - City or Town, State 12/8/99 LAUREL, MD | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee <i>James A. Morton</i> | | | | 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>SEPSIS</td> <td rowspan="4">Approximate Interval Between Onset and Death DAYS</td> </tr> <tr> <td>b.</td> <td>ADULT RESPIRATORY DISTRESS SYNDROME</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | SEPSIS | Approximate Interval Between Onset and Death DAYS | b. | ADULT RESPIRATORY DISTRESS SYNDROME | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | SEPSIS | Approximate Interval Between Onset and Death DAYS | | | | | | | | | | | | | | | | |
| | b. | ADULT RESPIRATORY DISTRESS SYNDROME | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC CANCER | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>J. Wang MD</i> | | | | 29c. License number RES-000 | | | | 29d. Date signed (Month, Day, Year) DECEMBER 2, 1999 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEAN WANG, JOHNS HOPKINS HOSPITAL, TOWER 110, 600 NORTH WOLFE STREET, BALTIMORE, MD 21287 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature <i>Benita B. Sparks</i> | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

030 0 0 030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38038

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORA

BLACK

2. Date of Death

Month

Day

Year

Nov 25 1999

3. Time of Death

20:40

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hosp. of Baltimore

Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

213-05-4673

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov 2, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7233 PARK HEIGHTS AVENUE #A

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOKKEEPER

16b. Kind of Business/Industry

ME RESTAURANT

17. Father's Name (First, Middle, Last)

SAMUEL

EPSTEIN

18. Mother's Name (First, Middle, Maiden Surname)

CECILIA

ASHMAN

19a. Informant's Name/Relationship (Type, Print)

MICHAEL BLACK / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7233 PARK HEIGHTS AVENUE #A - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANSHE EMUNAH AITZ CHAIM

Date

11/28/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subarachnoid hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cuong Ha

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Nov 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cuong T. Ha, 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

Brenda B. Sparks

State
RegistrarPatient also known as Black, Dora
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

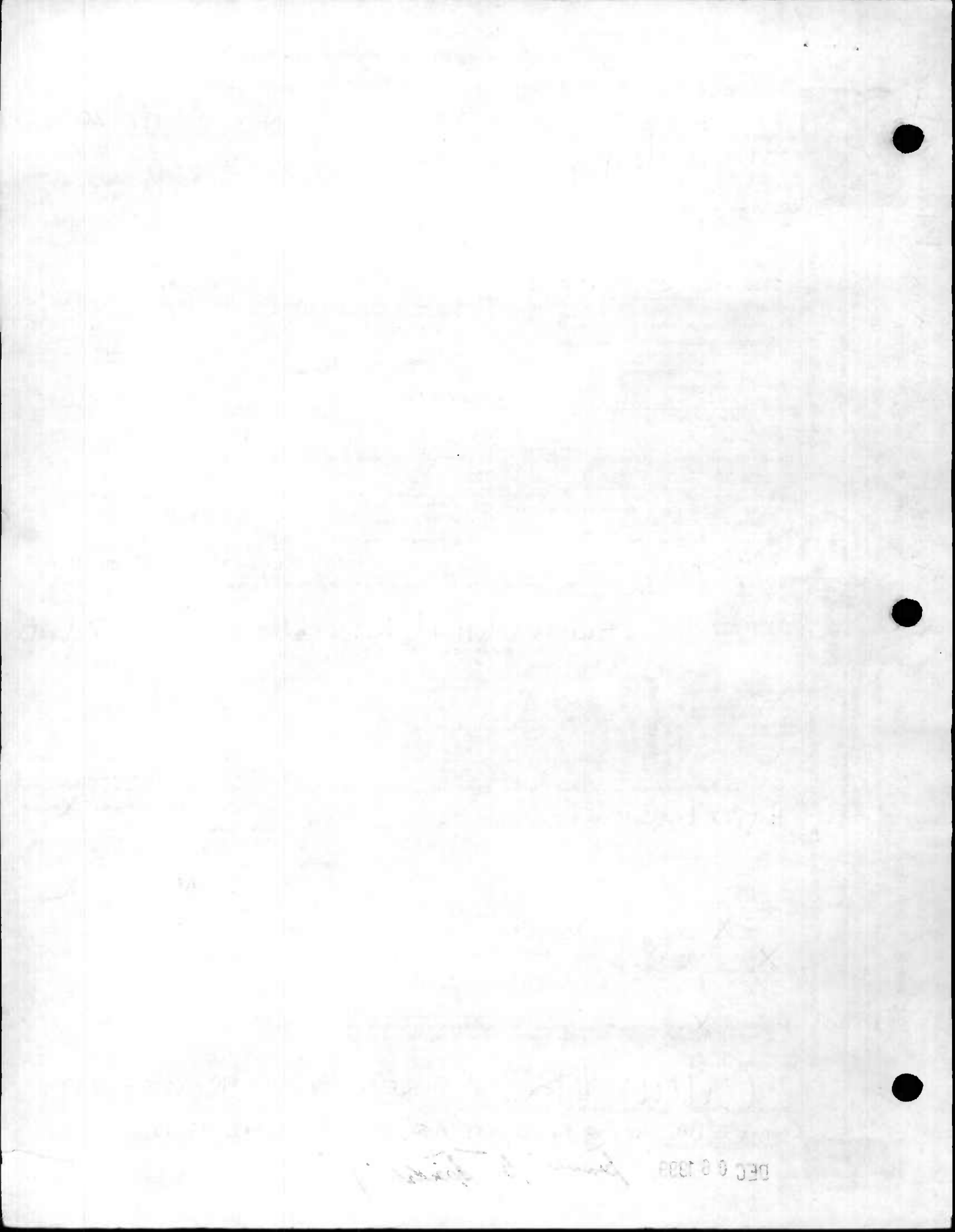
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



DEC 8 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38039

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last) RUTH BLUM | | 2. Date of Death Month Day Year NOVEMBER 27, 1999 | | 3. Time of Death 4:30 PM | |
| 4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE |
| 5. Social Security Number 053-38-3571 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) NOV. 17, 1905 | | 9. Birthplace (State or Foreign Country) RUSSIA | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 7218 PARK HEIGHTS AVENUE | | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME |
| 17. Father's Name (First, Middle, Last) DAVID GLASS | | | 18. Mother's Name (First, Middle, Maiden Surname) FANNY BINDER | | |
| 19e. Informant's Name/Relationship (Type, Print) FRAN GOODMAN / DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 STONEHENGE CIRCLE #7 - BALTIMORE, MD 21208 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ARARAT CEMETERY | | 20c. Location - City or Town, State 11/29/99 FARMINGDALE, NY | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. Alzheimers Disease Due to (or as a consequence of): | | | | | |
| b. Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D47683 | | 29d. Date signed (Month, Day, Year) 11/28/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street Suite 200 Reisterstown, MD | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 06 1983

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38040

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KLAUS BUCHDAHL

2. Date of Death

Month
11Day
26Year
99

3. Time of Death

8:36 PM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

216-16-8149

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 15, 1921

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE CO.

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7525 SLADE AVENUE

10f. Zip Code

21208

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

INSURANCE AGENT

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

ADOLPH

18. Mother's Name (First, Middle, Maiden Surname)

BUCHDAHL PAULA

ICHSTEIN

19a. Informant's Name/Relationship (Type, Print)

BETTE BUCHDAHL/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7525 SLADE AVENUE BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL MEMORIAL PARK-

Date

11/28/99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON BROS., INC.

8900 REISTERSTOWN RD. BALTO., MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEMORRHAGIC RADIATION CYSTITIS

2 MONTHS

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

1 MONTH

Due to (or as a consequence of):

c. PNEUMONIAE

3 DAYS

Due to (or as a consequence of):

d. SEPTIS

3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC BLADDER CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

PAUSE, MD

29c. License number

P-11195

29d. Date signed (Month, Day, Year)

11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL PAUSE - UNIVERSITY OF MARYLAND MEDICAL SYSTEM

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

Brenda G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James A. Smith

DEC 6 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38041**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

A. JEFFREY BLUMBERG

2. Date of Death
Month Day Year
November 29 19993. Time of Death
2:00pmFuneral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-42-1210

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 9, 1946

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6511 DEANCROFT RD.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

PROPRIETOR

16b. Kind of Business/Industry

JEFF BLUMBERG & ASSOCIATES

17. Father's Name (First, Middle, Last)

ISADORE

BLUMBERG

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE

KESELENKO

19a. Informant's Name/Relationship (Type, Print)

SUSAN BLUMBERG (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6511 DEANCROFT RD. BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HAR SINAI

Date

12/1/99

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Glioblastoma Multiforme

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

SCOTT REEDER MD, PhD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCOTT REEDER SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD

State
Registrar

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Blumberg, A Jeffrey
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0025.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 6 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38042

AMEND#26 PER MD. G778 12-6-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | | | |
|--|--|--|--|--|---------------------------|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Joseph Irvin Brown | | | | 2. Date of Death Month Nov. Day 29 Year 1999 | | | | 3. Time of Death 6:05 pm | |
| 4a. Facility Name (If not institution, give street and number) Montgomery County General Hospital | | | | 4b. City, Town, or Location of Death Olney | | | | 4c. County of Death Montgomery | |
| 5. Social Security Number 218-18-3355 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Day, Year) Nov. 4, 1923 | | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 14634 Bauer Drive Apt. 205 | | | | 10f. Zip Code 20853 | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaper | | | 16b. Kind of Business/Industry Landscaping | | |
| 17. Father's Name (First, Middle, Last) Irvin Brown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel Walker | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Catherine L. Brown (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14634 Bauer Dr. #205 Rockville MD 20853 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Linthicum Chapel Cemetery | | | Date 12/3/99 | | 20c. Location - City or Town, State Clarksville MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville MD 21784 | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction | | | | | | | | | 1 hour |
| Due to (or as a consequence of): b. Diabetes Mellitus | | | | | | | | | 7 years |
| Due to (or as a consequence of): c. Hypertension | | | | | | | | | 7 years |
| Due to (or as a consequence of): d. | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 014057 | | | 29d. Date signed (Month, Day, Year) November 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lewis Kellert, MD 4000 Olney Laytonsville Rd. Olney, MD. 20832 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

DEC 6 0 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38043

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ida Behrendt

2. Date of Death

Month Day Year
DECEMBER 3rd 1999

3. Time of Death

6:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

213 20 5562A

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 17, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1613 Cereal Street

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

Grayson Chemical

17. Father's Name (First, Middle, Last)

Alexander Ulakowski

18. Mother's Name (First, Middle, Maiden Surname)

Eva Ktosewski

19a. Informant's Name/Relationship (Type, Print)

William Behrendt / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1613 Cereal Street Baltimore, Maryland 21226

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

12/8/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Disease of Endometrial Cancer

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Ambalavanar Home Staff

29c. License number

B51596

29d. Date signed (Month, Day, Year)

DECEMBER 3rd 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Ambalavanar, North Arundel Hospital, 301 Hospital Drive, Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

B. Sparks

State Registrar

IDA BEHRENDT
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

A4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38044

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY BURNS

2. Date of Death

November 27 1999

3. Time of Death

12:21 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-10-4441

6. Sex

18 M 2 F

7. Age (In yrs. last birthday)

92

8. Date of Birth

Feb 14, 1907

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

526 N. Highland Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

merchant marine

16b. Kind of Business/Industry

shipping

17. Father's Name (First, Middle, Last)

Nicholas P. Burns

18. Mother's Name (First, Middle, Maiden Surname)

Ann Ertel

19a. Informant's Name/Relationship (Type, Print)

Charles Wargo/Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2930 E. Baltimore Street Baltimore, MD 21224

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage liver disease

Due to (or as a consequence of):

b. worsening renal insufficiency

Due to (or as a consequence of):

c. Squamous cell carcinoma of lung with possible liver metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

hepatitis C

peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

V. Ramulu, MD

29c. License number

20306

29d. Date signed (Month, Day, Year)

NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. RAMULU 4940 EASTERN AVE, BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

822 S. J. Gray

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38045

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARLENE KELLEY CARTER

2. Date of Death

Nov. 28, 1999

3. Time of Death

9:25 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

917 Mt. Holly Street

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220 18 4510

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Apr. 13, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

Maryland

10a. State

N/A

10b. County

BALTIMORE

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

917 Mt. Holly Street

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Engineer

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

JOHN H. KELLEY

18. Mother's Name (First, Middle, Maiden Surname)

LEONA JACKSON

19a. Informant's Name/Relationship (Type, Print)

YVONNE THOMAS / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

917 Mt. Holly Street BALTIMORE, Md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON MEMORIAL PARK

Date

12/1/99

20c. Location - City or Town, State

ARLINGTON, MD

21. Signature of Funeral Service Licenses

[Signature]

22. Name and Address of Facility

CHATELAIN - Harris Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, MD 21141

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Hemorrhage

Due to (or as a consequence of):

b. Cerebral Arteriosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D32263

29d. Date signed (Month, Day, Year)

12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMPING 1940 W Baltimore

21223

31. Date filed (Month, Day, Year)

REV 6 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38046

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth

G.

Clarke

2. Date of Death
Month Day Year
December 5, 1999

3. Time of Death
9:50 p.m.

4a. Facility Name (If not institution, give street and number)

BROADMEAD

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-46-2730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 03, 1915

9. Birthplace (State or Foreign Country)

Carlisle, PA.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13801 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

04

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles A. Goodyear

18. Mother's Name (First, Middle, Maiden Surname)

Maud Baker

19a. Informant's Name/Relationship (Type, Print)

Mr. William Charles Clarke, III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31 Brookwood Road Bedford, New York 10506

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

12/07/1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

STROKE

Due to (or as a consequence of):

b.

MULTI-INFARCT DEMENTIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 days

4 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Barbara Carroll MD

29c. License number

D38392

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA CARROLL M.D., 13801 YORK RD., COCKEYSVILLE

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Barbara Carroll

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38047

| | | | | | | | | |
|--|--|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ABDELLA CAMPBELL | | | | 2. Date of Death Month 11 Day 25 Year 1999 | | 3. Time of Death 7:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL BALTIMORE STREET BALTIMORE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 218-035387 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) May 14, 1907 | |
| | 9. Birthplace (State or Foreign Country) Md. | | 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3702 Denison Road | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator | | 16b. Kind of Business/Industry Baltimore City | | | | |
| 17. Father's Name (First, Middle, Last) Samuel J. Campbell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lena Webster | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James W. Beckwith | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 W. Lexington Street Baltimore, Md. 21223 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forrest Vet. | | Date Dec. 1 | | 20c. Location - City or Town, State Owings Mills, Md. | | |
| 21. Signature of Funeral Service Licensee Herbert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. UTI & loss sepsis. b. Prostate cancer - c. Pericardial vascular disease d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Gulab Shah | | | | 29c. License number D26750 | | 29d. Date signed (Month, Day, Year) 11/26/1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.R. GULAB SHAH MD-2300, Garrison Boulevard BALTIMORE | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature [Signature] 21216 | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint handwritten text]

DEC 1 1963

1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38048

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNA S. CERMAK

2. Date of Death

Month Day Year
Nov. 24, 1999

3. Time of Death

4:53 a.m.

4a. Facility Name (If not institution, give street and number)

Church Home

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-48-2676

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 4, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

101 N. Bond St.

10f. Zip Code

21231

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

C.H.Otto Schellhase

18. Mother's Name (First, Middle, Maiden Surname)

Minna Schulz

19a. Informant's Name/Relationship (Type, Print)

William E. Cermak / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1314 Milldam Rd., Towson, Md. 21286

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lorraine Park Cemetery

Date

11/27/99

20c. Location - City or Town, State

Woodlawn, Md.

21. Signature of Funeral Service Licensee

Wallace S. Brooks, Jr.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd., Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

C. Vergara-Soares MD

29c. License number

D 16619

29d. Date signed (Month, Day, Year)

Nov. 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Vergara-Soares, 101 N. Bond St., Balto., Md. 21231

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

C. Vergara-Soares

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-698-2020.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Page 2 of 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38049

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Calvert | | | | 2. Date of Death Month November Day 30 Year 1999 | | 3. Time of Death 9:47 pm | |
| | 4a. Facility Name (If not institution, give street and number) Harbor Hospital Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216 12 3615 | | 6. Sex M <input type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) 01 07 23 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4607 Ritchie Highway | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? U.S. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pile Driver | | 16b. Kind of Business/Industry Construction Union | | 17. Father's Name (First, Middle, Last) William Calvert | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Dora (not available) | | 19a. Informant's Name/Relationship (Type, Print) Bertha Calvert / wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7867 Crilley Road Apt. 493 Glen Burnie, Md. 21060 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Location - City or Town, State Towson, Maryland | | 20d. Date 12/2/99 | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | |
| 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 5 HOURS 12 YEARS | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 229807 | | 29d. Date signed (Month, Day, Year) 12/01/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLOS D. ZIGEL, M.D., SUITE 106, 1406 S. CRAIN HWY, GLEN BURNIE, MD 21061 | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

ORIGINAL

Robert A. ...
The ...
...

...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38050

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NICHOLAS JOHN CARR

2. Date of Death

Month Day Year
DECEMBER 5, 1999

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-01-6979

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 8, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No
XX

10e. Street and Number

1011 Cedarcroft Road

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married XX Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Confidential Papers for Lawyers

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Frank Carr

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Mary Schaefer

19a. Informant's Name/Relationship (Type, Print)

Josephine C. Carr

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 Cedarcroft Road Baltimore, Maryland 21212

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

12/8/99

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Dennis Hester Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

CORONARY ARTERIES DISEASE

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P. Mehta, M.D.

29c. License number

00041410

29d. Date signed (Month, Day, Year)

December 5th, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Joginder P. Mehta

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1944

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject.

2. The second part of the report is a description of the methods used in the study. This includes a description of the subjects, the experimental design, and the data collection procedures.

3. The third part of the report is a presentation of the results of the study. This includes a description of the data, a summary of the findings, and a discussion of the implications of the results.

4. The fourth part of the report is a conclusion. This includes a summary of the main findings of the study and a statement of the author's conclusions.

5. The fifth part of the report is a list of references. This includes a list of all the sources used in the study.

6. The sixth part of the report is an appendix. This includes a list of all the data collected during the study.

7. The seventh part of the report is a list of figures. This includes a list of all the figures included in the report.

8. The eighth part of the report is a list of tables. This includes a list of all the tables included in the report.

9. The ninth part of the report is a list of abbreviations. This includes a list of all the abbreviations used in the report.

10. The tenth part of the report is a list of symbols. This includes a list of all the symbols used in the report.

11. The eleventh part of the report is a list of footnotes. This includes a list of all the footnotes included in the report.

12. The twelfth part of the report is a list of appendices. This includes a list of all the appendices included in the report.

13. The thirteenth part of the report is a list of references. This includes a list of all the sources used in the study.

14. The fourteenth part of the report is an appendix. This includes a list of all the data collected during the study.

15. The fifteenth part of the report is a list of figures. This includes a list of all the figures included in the report.

16. The sixteenth part of the report is a list of tables. This includes a list of all the tables included in the report.

17. The seventeenth part of the report is a list of abbreviations. This includes a list of all the abbreviations used in the report.

18. The eighteenth part of the report is a list of symbols. This includes a list of all the symbols used in the report.

19. The nineteenth part of the report is a list of footnotes. This includes a list of all the footnotes included in the report.

20. The twentieth part of the report is a list of appendices. This includes a list of all the appendices included in the report.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38051

| | | | | | | | | | | |
|---|---|---|--|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joyce Lynn DeHaven | | | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 9:08 am | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center | | | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-86-9382 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | | 8. Date of Birth (Month, Day, Year) Jul 9, 1963 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 1473 Reynolds Street | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Store Manager | | | 16b. Kind of Business/Industry Sales | | | |
| 17. Father's Name (First, Middle, Last) Daniel Patrick DeHaven, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lucy Marie Hensley | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Daniel Patrick DeHaven, Jr. / Brother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1473 Reynolds Street, Baltimore Maryland 21230 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Mausoleum | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery, December 7, 1999 | | 20c. Location - City or Town, State Baltimore Maryland | | | | |
| 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. | | | | | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARREST Due to (or as a consequence of): f. SEPSIS Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 1 month | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bladder Cancer | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number P11411 | | 29d. Date signed (Month, Day, Year) 12/04/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 228 Greene St. (Dept of Urology) Baltimore MD 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Page 103

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38052

| | | | | | | | | | | |
|--|---|---------------------------------|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DOROTHY EMILY DOLLE | | | | | | 2. Date of Death Month Day Year DECEMBER 02 1999 | | 3. Time of Death 04:35 PM | |
| | 4a. Facility Name (If not institution, give street and number) 606 LANOITAN ROAD APT. H | | | | | | 4b. City, Town, or Location of Death MIDDLE RIVER | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 215 28 4444 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 24, 1912 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | 10e. Street and Number 606 Lanoitan Road Apt. H | | 10f. Zip Code 21220 | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) John Miller | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hattie Shoemaker | | | | |
| 19a. Informant's Name/Relationship (Type, Print) August Dolle / Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Lanoitan Rd. Apt. H Baltimore, Md. 21220 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | Date 12/7/99 | | 20c. Location - City or Town, State Glen Burnie, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>Donna M. Zimicowski</i> | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Phil P. Militello MD deputy</i> | | | | 29c. License number D18667 | | 29d. Date signed (Month, Day, Year) December 2, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phil P Militello MD 22 S. Greene St. Baltimore, MD 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38053

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Lawrence Nmi Dickey</u> | | | | | 2. Date of Death Month <u>November</u> Day <u>30</u> Year <u>1999</u> | | | 3. Time of Death <u>2:17 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical Center</u> | | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | | 4c. County of Death <u>Baltimore</u> | |
| Funeral Director | 5. Social Security Number <u>214-64-0839</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>36</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>2-16-63</u> | | 9. Birthplace (State or Foreign Country) <u>MD.</u> | |
| | Usual Residence of Decedent | | | | | 10. State <u>MD.</u> | | 10b. County <u>BALTIMORE</u> | | 10c. City, Town or Location <u>RANDALLSTOWN</u> |
| 10a. Street and Number <u>3503 BEAGLE LANE APT. 202</u> | | | | | 10f. Zip Code <u>21133</u> | | 10g. Citizen of What Country? <u>USA</u> | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>-12-</u> College (1-4 or 5+) <u>-0-</u> | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>LABORER</u> | | | 16b. Kind of Business/Industry <u>FACTORY</u> | | |
| 17. Father's Name (First, Middle, Last) <u>LEO DICKEY</u> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>MARY MARTIN</u> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>MARY DICKEY (MOTHER)</u> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2300 KEYSWAY CT. BALTIMORE, MARYLAND 21244</u> | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>CEDAR HILL CEMETERY</u> | | | Date <u>12-4-99</u> | | 20c. Location - City or Town, State <u>GLEN BURNIE, MARYLAND</u> | | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | | | | 22. Name and Address of Facility <u>PHILLIPS FUNERAL HOME, P.A.</u> <u>1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</u> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): | | | | | | | | | | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): | | | | | | | | | | |
| c. _____ Due to (or as a consequence of): | | | | | | | | | | |
| d. _____ Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <u>[Signature] MD Medicine Resident</u> | | | | | 29c. License number <u>AU 4176435 T12406</u> | | | 29d. Date signed (Month, Day, Year) <u>November 30, 1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Frank Duy Duc Trinh, MD 22 S. Greene Street, Baltimore, MD 21201</u> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>DEC 6 1999</u> | | | 32. Registrar's Signature <u>[Signature]</u> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 9 1939

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38054

| | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|--|---|---|----|------------------------------------|----------------------------------|--------------|----|------------------------|----------------------------------|-----------------|----|-----------------------------|----------------------------------|-----------------|----|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen R. Ellett | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 1:30 AM | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 7806 Ruxwood Road | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 214-24-1123 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6-24-1922 | | 9. Birthplace (State or Foreign Country) West Virginia | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 10a. Street and Number 7806 Ruxwood Road | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? U. S. A. | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Frank Ratcliffe | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Catran | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert E. Ellett (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7806 Ruxwood Road, Towson, Maryland 21204 | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | Date 12-7-99 | | 20c. Location - City or Town, State Towson, Maryland | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr. | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Gastrointestinal Hemorrhage</td> <td>Due to (or as a consequence of):</td> <td>acute</td> </tr> <tr> <td>b.</td> <td>Hepatic Failure</td> <td>Due to (or as a consequence of):</td> <td>2 months</td> </tr> <tr> <td>c.</td> <td>Short Bowel Syndrome</td> <td>Due to (or as a consequence of):</td> <td>one year</td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Gastrointestinal Hemorrhage | Due to (or as a consequence of): | acute | b. | Hepatic Failure | Due to (or as a consequence of): | 2 months | c. | Short Bowel Syndrome | Due to (or as a consequence of): | one year | d. | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Gastrointestinal Hemorrhage | Due to (or as a consequence of): | acute | | | | | | | | | | | | | | | | | | | | |
| | b. | Hepatic Failure | Due to (or as a consequence of): | 2 months | | | | | | | | | | | | | | | | | | | | |
| | c. | Short Bowel Syndrome | Due to (or as a consequence of): | one year | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | |
| Pancreatitis Sepsis Ischemic Bowel Infarction | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier B. Bokhari MD | | | | 29c. License number D-26594 | | 29d. Date signed (Month, Day, Year) Dec 4 1999 | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. BOKHARI MD, 6701 N. Charles St. Baltimore MD 21204 | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. 10. 1956

2. 10. 1956

3. 10. 1956

4. 10. 1956

5. 10. 1956

6. 10. 1956

7. 10. 1956

8. 10. 1956

9. 10. 1956

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14. 10. 1956

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16. 10. 1956

17. 10. 1956

18. 10. 1956

19. 10. 1956

20. 10. 1956

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38055

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) LEOLA B EMBER | | | | 2. Date of Death Month Day Year NOV. 30 1999 | | 3. Time of Death 8:15PM | |
| 4a. Facility Name (If not Institution, give street and number) GENESIS BRIGHTWOOD NURSING HOME | | | | 4b. City, Town, or Location of Death LUTHERVILLE | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 215-09-0304 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG 18, 1906 | |
| 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location LUTHERVILLE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 515 BRIGHTFIELD RD. | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE SECRETARY | | 16b. Kind of Business/Industry LEVINDALE | | | |
| 17. Father's Name (First, Middle, Last) MOSES BESKIN | | | | 18. Mother's Name (First, Middle, Maiden Surname) VIVIAN (UNKNOWN) | | | |
| 19a. Informant's Name/Relationship (Type, Print) STEPHEN EMBER (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8314 CARRLEIGH PARKWAY SPRINGFIELD, VA 22152 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH TFILOH | | Date 12/2/99 | | 20c. Location - City or Town, State BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. atherosclerotic cardiovascular disease 20 years Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cerebrovascular disease colitis | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 045432 | | 29d. Date signed (Month, Day, Year) December 1, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 crossroads Drive Suite 400 Owings Mills, MD 21117 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38056

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--------------------------------------|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GARNETT ELLIOTT | | | | 2. Date of Death Month Day Year NOVEMBER 30, 1999 | | 3. Time of Death 10:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF GLEN BURNIE | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 215-12-5921 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUNE 24, 1923 | | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County ANNE ARUNDEL | 10c. City, Town or Location GLEN BURNIE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 2011 NORMAN ROAD | | | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | |
| | 17. Father's Name (First, Middle, Last) ALFRED KILBOURNE | | | | 18. Mother's Name (First, Middle, Maiden Surname) AGNES BURKHEART | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) PATRICIA L. CARR- DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 NORMAN ROAD, GLEN BURNIE, MARYLAND 21060 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK | | Date 12/4/99 | | 20c. Location - City or Town, State ELKRIDGE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Euphysema | | | | | | | Approximate Interval Between Onset and Death 10 years |
| | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D20094 | | 29d. Date signed (Month, Day, Year) 12/01/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot Gorbaty mo, 7845 Oakwood Rd, Glen Burnie, md, 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38057

Reg. No.

| | | | | | | | | | | | | |
|---|---|---------------------------|---|---|--|---|---|---------------------------------|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Paula C. Floystad | | | | | | 2. Date of Death Month Day Year December 4, 1999 | | | 3. Time of Death 00:06 | | |
| | 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center | | | | | | 4b. City, Town, or Location of Death Towson | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 218-36-3854 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Dec. 5, 1939 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 5201 Carter Avenue | | | | | | 10f. Zip Code 21214 | | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Claims Secretary | | | 16b. Kind of Business/Industry Benefit Systems | | | |
| 17. Father's Name (First, Middle, Last) John Dembeck, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Unknown | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Finn O. Floystad / Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Carter Avenue Baltimore, MD 21214 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | | Date 12/6/99 | | 20c. Location - City or Town, State Towson, Maryland | |
| 21. Signature of Funeral Service Licensee  Timothy Harman | | | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic breast carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death greater than 1 month | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number D28885 | | | 29d. Date signed (Month, Day, Year) December 4, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard L. Siegel, M.D. - GBMC 6701 N. Charles St., Baltimore MD 21204 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Number 1000000-1

1000000-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38058

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROSE FRIEDMAN | | | | 2. Date of Death Month Day Year NOVEMBER 28, 1999 | | 3. Time of Death 10:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 216-32-4704 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) JUN. 28, 1913 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location RANDALLSTOWN | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3706 TRENT ROAD | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) PHILIP LEVIN | | 18. Mother's Name (First, Middle, Maiden Surname) KATHY ROSENBERG | | 19a. Informant's Name/Relationship (Type, Print) STANLEY FRIEDMAN / SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 GLYDON DRIVE - REISTERSTOWN, MD 21136 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHEVRA AHAVAS CHESED | | 20c. Location - City or Town, State 12/1/99 RANDALLSTOWN, MD | | | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | 23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiopulmonary arrest | | Approximate Interval Between Onset and Death | |
| | 23a. Pert. 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 23a. Pert. 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic heart disease | | Due to (or as a consequence of): | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 23a. Pert. 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer of tongue. | | Due to (or as a consequence of): | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D 30335 | | 29d. Date signed (Month, Day, Year) 11/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRAN WISTER, MD 4000 Old Court Rd; BALTIMORE, MD 21208 | | 31. Data filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 4 1940

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38059

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES ELIZABETH FORREST

2. Date of Death

DECEMBER 4, 1999

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-14-9119

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 18, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

333 Dixie Drive

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

XX Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Parochial School

17. Father's Name (First, Middle, Last)

William Joseph Forrest

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Lockwood

19a. Informant's Name/Relationship (Type, Print)

Sr. M. Suzanne Moore SSND

Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5990 Old Washington Road Elkridge Maryland 21075

20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

12/7/99

20c. Location - City or Town, State

Lutherville, Maryland

21. Signature of Funeral Service Licensee

Dennis Stecher Knapp

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

PNEUMONIA

Approximate
Interval Between
Onset and Death
4 DAYSImmediate Cause (Final
disease or condition
resulting in death)

a. END STAGE CHRONIC OBSTRUCTIVE

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
PULMONARY DISEASE

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

29c. License number

041410

29d. Date signed (Month, Day, Year)

December 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joginder P Mehta M.D. 7601 Osler Drive Towson, Maryland 21204

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Bawa B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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99-7201-005

MICHAEL

GAYLE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38060

AMEND ITEMS: #23 PART I, 27 PER MEO G778 12-17-99 WR.

| | | | | | | | | |
|--|---|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michael Eugene Gayle | | | | 2. Date of Death Month Day Year DECEMBER 1, 1999 | | 3. Time of Death 4:14 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 258 BALTIMORE AVE | | | | 4b. City, Town, or Location of Death DUNDALK | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 218-62-4372 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 47 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 26, 1952 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 258 Baltimore Avenue | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years 2 Years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security | | 16b. Kind of Business/Industry Baltimore Gas & Electric Company | | |
| 17. Father's Name (First, Middle, Last) Stephen Eugene Gayle | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Jean Carnes | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Russell S. Gayle (Brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Aldworth Road Dundalk, Maryland 21222 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | Date 12/6/1999 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALCOHOLIC STEATO-HEPATITIS a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DECEMBER 2, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38061

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Margaret Gluckert

2. Date of Death

Month
DEC

Day

3,

Year

1999

3. Time of Death

6:10pm

4a. Facility Name (If not institution, give street and number)

12 Waters Road

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

247-88-9944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JUNE 25, 1947

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Waters Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John E. Frick

18. Mother's Name (First, Middle, Maiden Surname)

Mary Margaret Beach

19e. Informant's Name/Relationship (Type, Print)

John Carlton Gluckert/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Waters Road Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/4/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Breast Cancer - Stage IV

Approximate Interval Between Onset and Death

8 years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mayer GovboTy, MD

29c. License number

027938

29d. Date signed (Month, Day, Year)

December 4, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mayer GovboTy, MD, 795 Aqueduct Road Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38062

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Henry Goldman

2. Date of Death
Month Day Year

December 4 1999

3. Time of Death

816am

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

203-09-1816

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 12, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5616 Magnolia Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

A.T. & T.

17. Father's Name (First, Middle, Last)

Charles Frederick Goldman

18. Mother's Name (First, Middle, Maiden Surname)

Florence Readinger

19a. Informant's Name/Relationship (Type, Print)

Mrs. Gladys Goldman / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5616 Magnolia Avenue Baltimore, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

12/7/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Timothy Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Post-Obstructive Pneumonia Secondary to Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Arthur Li, Medical Resident

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Li, Sinai Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Goldman, Donald
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

A4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38063

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN M. GRAY

2. Date of Death

Month Day Year
DEC. 2, 1999

3. Time of Death

0845

4a. Facility Name (If not institution, give street and number)

Carroll County Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

215-22-1868

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 7, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5318 Wendy Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Luther Booz

18. Mother's Name (First, Middle, Maiden Summa)

Anna McCleary

19a. Informant's Name/Relationship (Type, Print)

Gary C. Gray (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10209 Green Clover Drive Ellicott City, MD 21042

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Paran Church Cem.

Date

12/6/99

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

Jackie H. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME

4107 Wilkens Avenue

Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

acute myocardial infarction secondary to coronary artery disease 3 yrs

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation☐ Accident ☐ Could not be determined☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

0097765

29d. Date signed (Month, Day, Year)

12/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William F. Renner 3222 St. Paul Street, Baltimore, Maryland 21202

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Renner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-534-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 9 1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38064

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy R. Gallik

2. Date of Death

November 30, 1999 8:10 A.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-14-0875

6. Sex

1 ☐ M 2 ☒ F

7. Age (In Yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 24, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

556 Brisbane Road

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

9th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Theodore Green

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Ziegler

19a. Informant's Name/Relationship (Type, Print)

Andrew A. Gallik, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5618 Wasena Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 12/6/99 Owings Mills, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Guarita R. Thomas

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Encephalopathy

Due to (or as a consequence of):

b. Liver Cirrhosis

Due to (or as a consequence of):

c. PNEUMONIA.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Smith

29c. License number

D43977

29d. Date signed (Month, Day, Year)

November 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Omyka Oretunji, 301 Hospital Drive, Glen Burnie, MD. 21061.

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

B. Smith

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Dorothy Gallik
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3000.

100 6 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38065

| | | | | | | | | |
|--|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John B. Green Jr. | | | | 2. Date of Death Month Day Year NOV. 29, 1999 | | 3. Time of Death 1730 PM | |
| | 4a. Facility Name (If not institution, give street and number) 4001 WILSBY AVENUE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NIA | |
| Funeral Director | 5. Social Security Number 218-28-2222 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JAN. 7, 1933 | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County NIA | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 4001 Wilsby Avenue | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2yrs. College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Steel | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) John B. Green Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mamie Penix | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Shir Lee Green - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Harlem Ave. Balto, md. 21216 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans | | Date 12-6-99 | | 20c. Location - City or Town, State Owings Mills, MD. | |
| | 21. Signature of Funeral Service Licensee Quinn March | | 22. Name and Address of Facility Gary E. March Funeral Home P.A. 2740 Fredrickson Pass Balto, MD 21229 | | | | | |
| Physician /Medical Examiner | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| | b. Due to (or as a consequence of): | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Theodore M. King | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature James B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

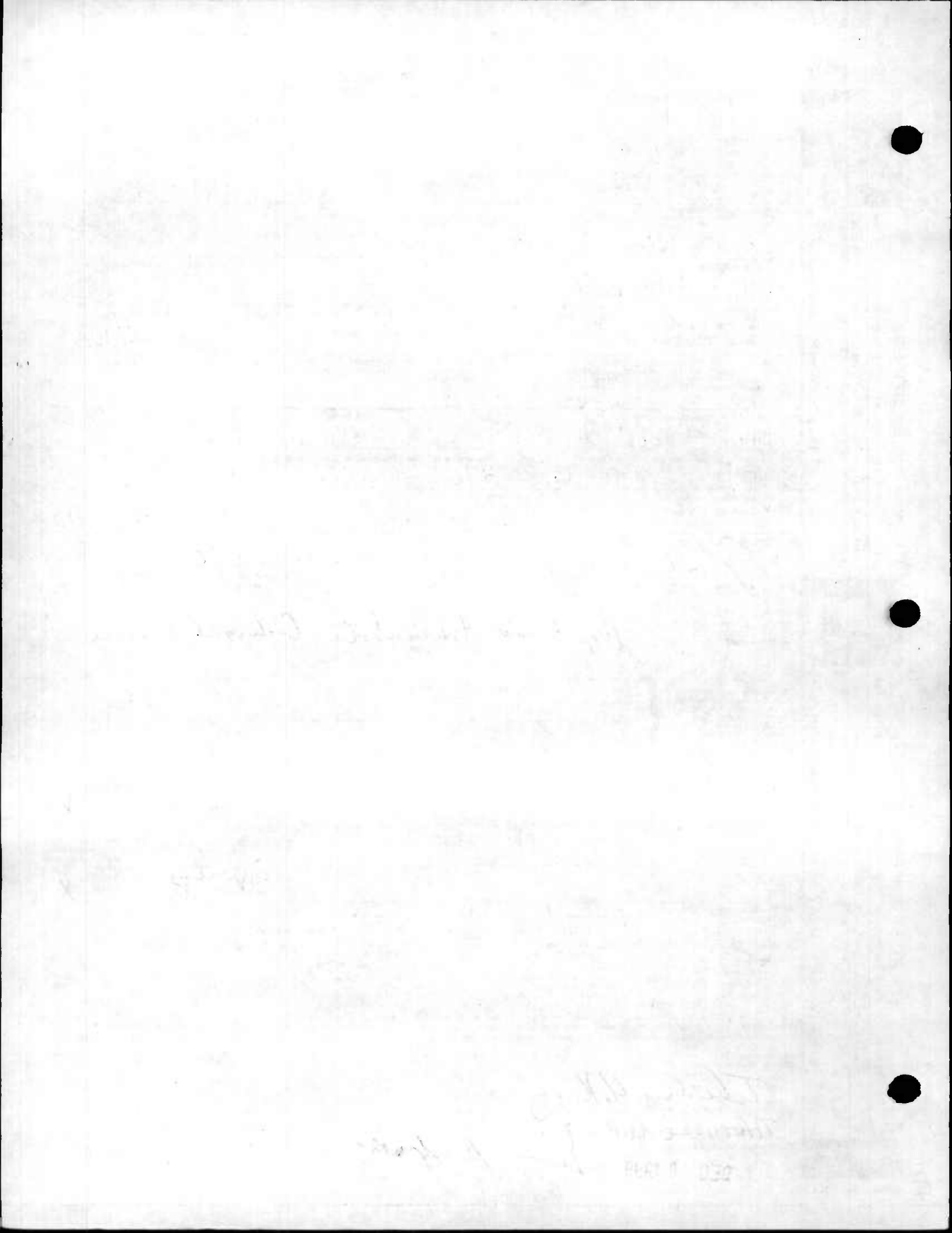
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38066

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alberta George

2. Date of Death

November 8 1999

3. Time of Death

5:55 AM

4a. Facility Name (If not institution, give street and number)

Blue Point Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-22-2112

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 24, 1921

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2525 W. Belvedere Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Housekeeping

17. Father's Name (First, Middle, Last)

Willie Civals

18. Mother's Name (First, Middle, Maiden Surname)

Idel Cey

19a. Informant's Name/Relationship (Type, Print)

Dina Alsip/cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) instate

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Colon Carcinoma
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GI Bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D27569

29d. Date signed (Month, Day, Year)

11/24/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Allen Nettelman 1838 Greene Tree Rd #300

State
Registrar

31. Date filed (Month, Day, Year)

DEC

6 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38067

| | | | | | | | | |
|---|---|--|---|--------------------------------|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) OTIS HUGHES | | | | 2. Date of Death Month Day Year DECEMBER FIRST 1999 | | 3. Time of Death 8:06 PM | |
| | 4a. Facility Name (If not institution, give street and number) Hopkins Bayview | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213 62 0428 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 30, 1953 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 604 N. BOULDER STREET | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | 16b. Kind of Business/Industry Self Employed | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Otis Hughes, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) LENA HOGG NEALY | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Theresa Hughes / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Maryland Drive Baltimore, MD 21212 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Washell Memorial Cemetery | | 20c. Location - City or Town, State Dundalk, Maryland | | 20d. Date of Disposition 12/5/99 | |
| | 21. Signature of Funeral Service Licensee [Signature] | | 22. Name and Address of Facility CHARITABLE - HARMON - 5540 KESTERSON ROAD BALTIMORE, MD 21205 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. UPPER GASTROINTESTINAL BLEED Due to (or as a consequence of): | | | | | | | 2 DAYS |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. EROSIVE GASTRITIS Due to (or as a consequence of): | | | | | | | 1 WEEK |
| | c. Due to (or as a consequence of): d. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATITIS C INFECTION END STAGE RENAL DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier [Signature] M.D. | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) DECEMBER 2, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART M. LEVINE, M.D. / JOHNS HOPKINS HOSPITAL BALTIMORE MD | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38068

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>LOIS MEREDITH HENRY</i> | | | | 2. Date of Death Month <i>DEC</i> Day <i>1</i> Year <i>1999</i> | | 3. Time of Death <i>3:15A</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>KESWICK NURSING HOME</i> | | | | 4b. City, Town, or Location of Death <i>BALTIMORE</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>213-62-5789</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>74</i> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>JAN. 27, 1925</i> | 9. Birthplace (State or Foreign Country) <i>Virginia</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>Maryland</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>BALTIMORE</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number <i>1311 DARTMOUTH AVE</i> | | | | 10f. Zip Code <i>21234</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th grade</i> | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSEWIFE</i> | | 16b. Kind of Business/Industry <i>OWN HOME</i> | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <i>VERNEIL STOKES</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>JENNIE JOHNS</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>DEBRA HENRY DAUGHTER</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1311 DARTMOUTH AVE BALTIMORE, Maryland 21234</i> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>PLEASANT OAK BAPTIST CHURCH</i> | | Date <i>Victorian, Virginia</i> | | 20c. Location - City or Town, State <i>Victorian, Virginia</i> | |
| | 21. Signature of Funeral Service Licensee <i>Sperry Harris</i> | | 22. Name and Address of Facility <i>5540 KENTSTOWN ROAD BALTIMORE, MD 21215</i> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Progressive Dementia</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Progressive Dementia</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death <i>years</i> | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | |
| | 28a. Date of Injury (Month, Day Year) | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>W.A. Riley, MD</i> | | 29c. License number <i>D25205</i> | | 29d. Date signed (Month, Day, Year) <i>December 1, 1999</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>W.A. Riley GMC 6701 N. Charles St. Balto. MD 21205</i> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <i>DEC 6 1999</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DEC 6 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38069

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ta-Mar Hamilton | | | | 2. Date of Death Month Day Year December 01, 1999 | | 3. Time of Death 11:24 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-96-6187 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 5 | | 8. Date of Birth (Month, Day, Year) June 3, 1999 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1909 E.Lanvale Street | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant | | 16b. Kind of Business/Industry N/A | | 17. Father's Name (First, Middle, Last) Larry Hamilton | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Shawntel Rice | | 19a. Informant's Name/Relationship (Type, Print) Shawntel Rice | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 E.Lanvale Street Baltimore, Md. 21213 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Zion Cemetery | | 20c. Location - City or Town, State 12-6-99 Lansdowne, Maryland | | 21. Signature of Funeral Service Licensee Lewis T. Gwynn | | 22. Name and Address of Facility Lewis T. Gwynn Funeral Home | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Blunt Force Injuries | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicidal <input checked="" type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) 11/27/99 | |
| | 28b. Time of Injury (Month, Day, Year) 10:30AM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Child Abuse | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Md. | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Joseph Pestaner, M.D. | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 02, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner | | 31. Data filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature [Signature] | | 33. Registrar's Name [Signature] | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38070

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey M. Herman

2. Date of Death

Month Day Year
December 04, 1999 04:00 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

213-20-9536

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 7, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

30 Charlote Place

10f. Zip Code

21218

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerical Worker

16b. Kind of Business/Industry

B and O Railroad

17. Father's Name (First, Middle, Last)

John W. Morris

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina Ritz

19a. Informant's Name/Relationship (Type, Print)

William J. Herman / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 Charlote Place Baltimore, Maryland 21218

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

12/8/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee Timothy Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Malignant melanoma

Approximate Interval Between Onset and Death

9 months

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P30929

29d. Date signed (Month, Day, Year)

12/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Celano, MD 6565 N. Charles ST, BALTIMORE MD 21204

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Herman, Audrey

AH

1972

1972

1972

1972

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38071

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARIE HARRIS | | | | 2. Date of Death Month Day Year DECEMBER 1, 1999 | | | | 3. Time of Death 01:30 AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death | | | | | | | |
| Funeral Director | 5. Social Security Number 215-28-7138 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 11-19-1929 | | 9. Birthplace (State or Foreign Country) MD | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County | | 10c. City, Town or Location BALTIMORE | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 4403 BELLE AVE | | | | 10f. Zip Code 21207 | | | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER | | | | 16b. Kind of Business/Industry EDUCATION | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) WILLIAM P. HAWKINS | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARGARET KELLEHER | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MR FRANCIS HAWKINS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4403 BELLE AVE, BALTIMORE, MD 21207 | | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD NATIONAL | | Date 12-7-99 | | 20c. Location - City or Town, State LAUREL MD. | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Michael Ziegler | | | | 22. Name and Address of Facility 4600 LIBERTY HEIGHTS BALTO, MD, 21207 | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. DISSEMINATED INTRAVASCULAR COAGULATION 10R Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. ABDOMINAL AORTIC ANEURYSM Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | c. ISCHEMIC BOWEL Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | |
| | 29b. Signature and title of certifier Arhai THAI, M.D. | | | | 29c. License number AES 000 | | | | 29d. Date signed (Month, Day, Year) DECEMBER 1, 1999 | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215 | | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | |

ORIGINAL

Handwritten signature

DEC 06 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38072

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE W. HARRIS

2. Date of Death

DEC 1 1999

3. Time of Death

1 AM

4a. Facility Name (If not institution, give street and number)

6580 WOVEN-MOON BEAM

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

227-18-5010

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 10, 1921

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State
MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6580 WOVEN-MOON BEAM

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LONGSHOREMAN

16b. Kind of Business/Industry

STEAMSHIP TRADE

17. Father's Name (First, Middle, Last)

GEORGE HARRIS

18. Mother's Name (First, Middle, Maiden Surname)

LANDONIA JEFFRIES

19a. Informant's Name/Relationship (Type, Print)

BLANCHE LEE-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1409 Florida, Woodbridge VA 22191

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Memorial Park 12-6-99 Randallstown Md

Date

12-6-99

20c. Location (City or Town, State)

Randallstown Md

21. Signature of Funeral Service Licensee

Bryon S. Stanis

22. Name and Address of Facility

March Funeral Home West Inc
4300 Wabash Ave. Balto. Md 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Parkinson's Disease

Due to (or as a consequence of):

b. Alcoholic Liver Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

~15 years

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only)2 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bryon S. Stanis MD

29c. License number

D31473

29d. Date signed (Month, Day, Year)

Dec 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Elliot City MD 21042

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

Bryon S. Stanis

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint handwritten notes at the bottom of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38073
Reg. No.Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George E. Hopkins

2. Date of Death
Month Day Year
NOV. 29, 19993. Time of Death
12:46pm

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GIEN BURNIE

4c. County of Death

AA COUNTY

Funeral
Director

5. Social Security Number

215 10 4641

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 30, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

307 Orchard Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Meat Packer

16b. Kind of Business/Industry

Esskay

17. Father's Name (First, Middle, Last)

John Hopkins

18. Mother's Name (First, Middle, Maiden Surname)

Ann Gorecha

19a. Informant's Name/Relationship (Type, Print)

Raymond J. Hopkins / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

206 Hance Avenue N. Linthicum, Maryland 21090

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park 12/2/99 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

► Jerome Gramuscu

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225

Gonce Funeral Home P.A.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Lung Disease

Deafness

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation☐ Accident ☐ Could not be determined☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Robert B. Kwoon

29c. License number

N17713

29d. Date signed (Month, Day, Year)

11/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Old Court Road, Annapolis, Maryland 21208

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Hopkins, George E.
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

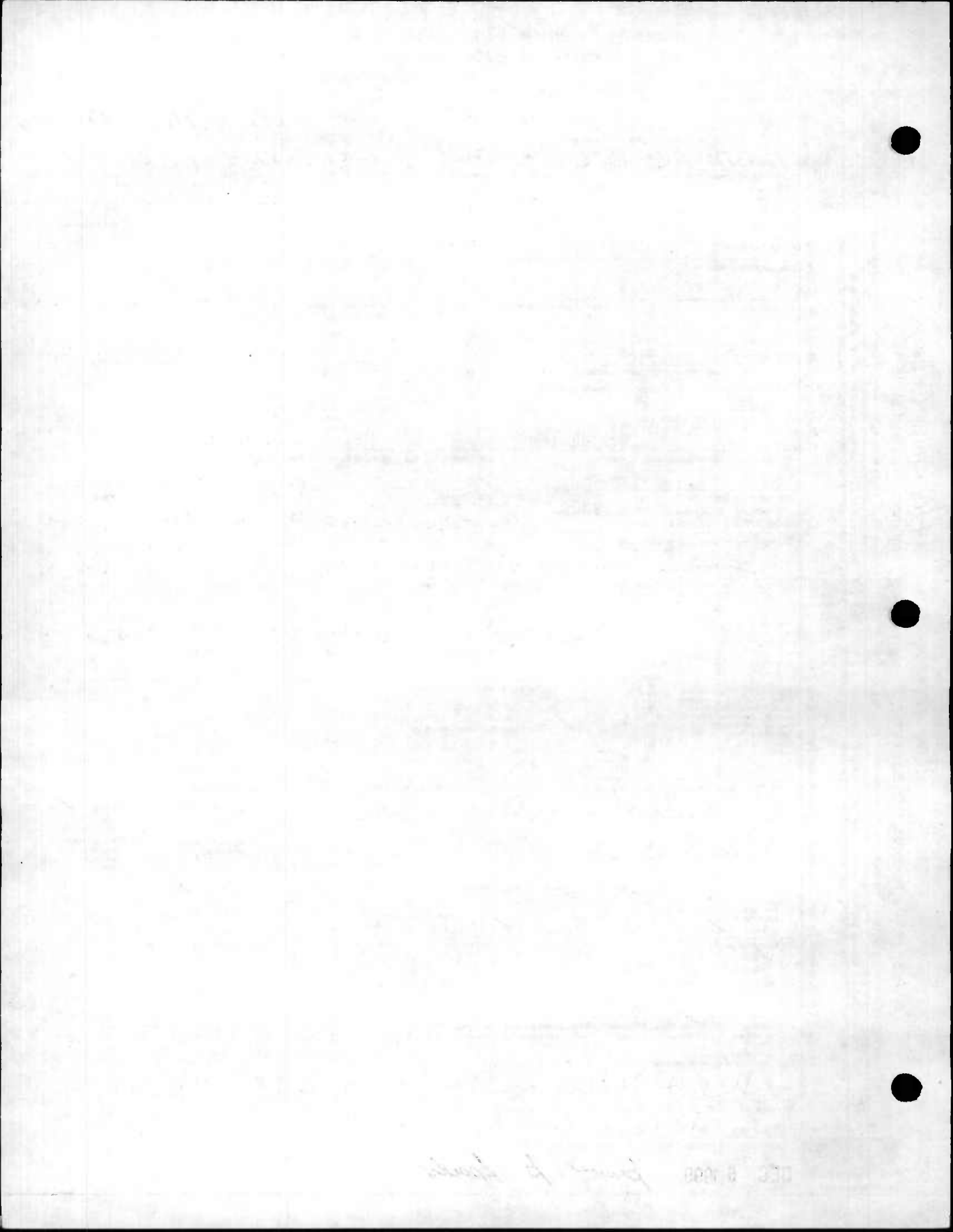
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38074

| | | | | | | | | | | | |
|---|---|---|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Russell Heberle</i> | | | | 2. Date of Death Month <i>November</i> Day <i>23</i> Year <i>1999</i> | | | | 3. Time of Death <i>7:47pm</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | | | 4c. County of Death <i>N/A</i> | | |
| Funeral Director | 5. Social Security Number <i>212 28 0497</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>68</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Sept. 23, 1931</i> | | 9. Birthplace (State or Foreign Country) <i>Washington, D.C.</i> | | |
| | 10a. State <i>Maryland</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>Baltimore</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number <i>1720 West Pratt Street</i> | | 10f. Zip Code <i>21223</i> | | 10g. Citizen of What Country? <i>U.S.</i> | | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4th</i> Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Master Plasterer</i> | | 16b. Kind of Business/Industry <i>Self Employed</i> | | 17. Father's Name (First, Middle, Last) <i>John Louis Heberle</i> | | 18. Mother's Name (First, Middle, Maiden Sumama) <i>Ruth Alma</i> | |
| 19a. Informant's Name/Relationship (Type, Print) <i>John Heberle Sr. / Son</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1720 West Pratt Street Baltimore, Maryland 21223</i> | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hilltop Service Corp.</i> | | 20c. Location - City or Town, State <i>11/30/99 Towson, Maryland</i> | | 21. Signature of Funeral Service Licensee <i>Danna M. Zmiorowski</i> | |
| 22. Name and Address of Facility <i>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</i> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Michael Rolnick MD</i> | | 29c. License number <i>D41396</i> | |
| 29d. Date signed (Month, Day, Year) <i>November 24, 1999</i> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael Rolnick 22 South Greene Street Baltimore, Maryland 21201</i> | | 31. Data filed (Month, Day, Year) <i>DEC 6 1999</i> | | 32. Registrar's Signature <i>Benjamin Sparks</i> | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38075

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes T. Holt

2. Date of Death
Month Day Year

December 02 1999 0840 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

216 34 9713

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 18, 1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town, or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3917 Park Heights Ave

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Elem

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

never worked

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Joseph Holt

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Holt

19a. Informant's Name/Relationship (Type, Print)

James A. Holt (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Lochearn Drive Baltimore MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Western Star Cemetery 12-6-99 Catonsville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Albert P. Weber

22. Name and Address of Facility

Albert P. Weber Funeral Home 638 N. Gilmore St. Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Karen Weber

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

December 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen Weber Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

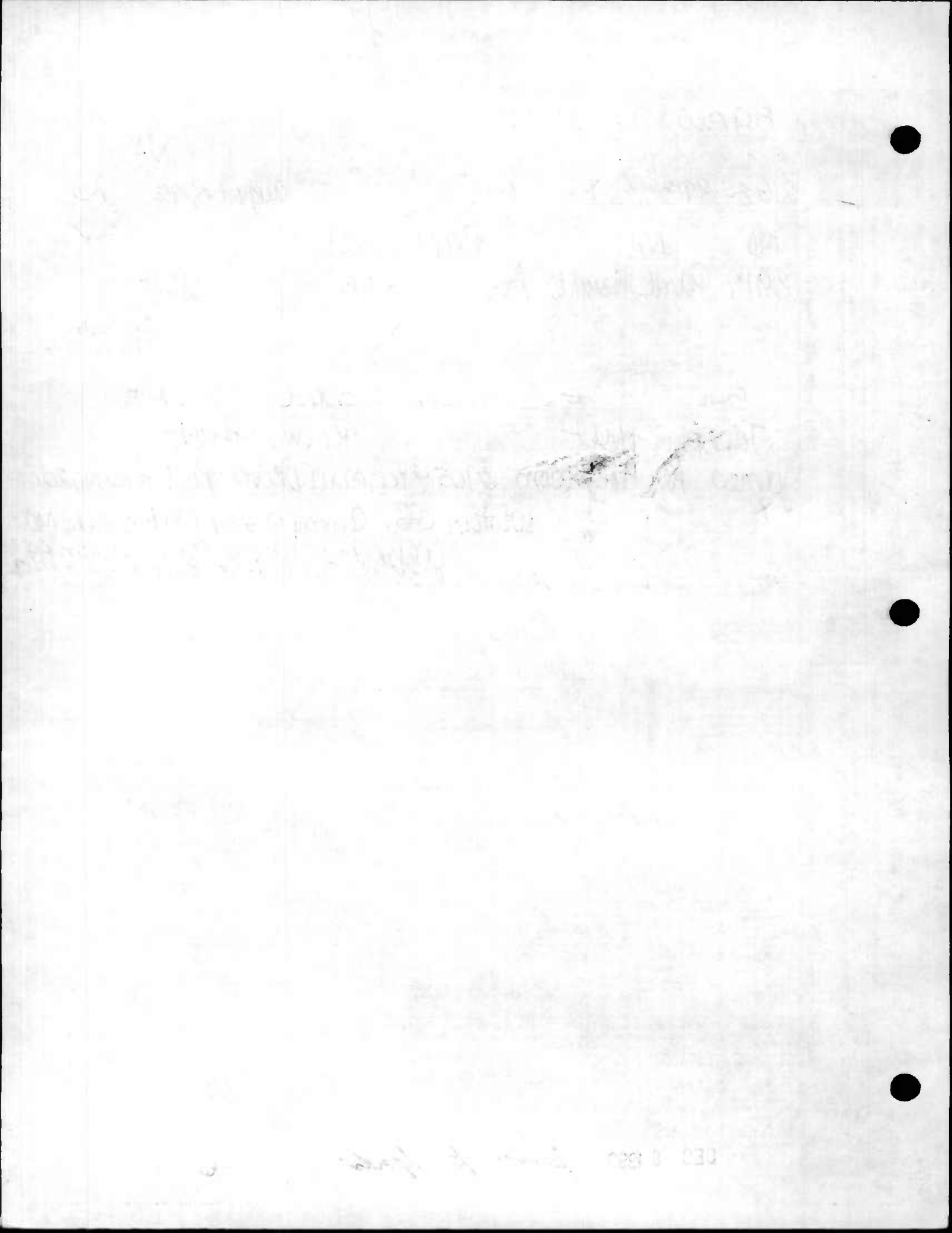
Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-6000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death.

Reg. No.

99 38076

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Larry William Healy

2. Date of Death
Month Day Year
December 2 1999

3. Time of Death
9:42 AM

4e. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-78-4875

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

January 4 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20622 W. Liberty Road

10f. Zip Code

21144

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1979-1983

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Respiratory Therapist

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Lawrence Kevin Healy

18. Mother's Name (First, Middle, Maiden Surname)

Mary Eileen Ott

19a. Informant's Name/Relationship (Type, Print)

Lawrence K. Healy (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2101 E. Lombard Street Baltimore, Maryland 21231

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

12/3/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Steven T. Bitt

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small cell cancer of the Lung

Approximate Interval Between Onset and Death

8 months

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balto. md 2120x

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38077

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Erwin C. Hartung

2. Date of Death

Month

Day

Year

NOV. 30 1999 6:20 AM

3. Time of Death

N/A

4a. Facility Name (If not institution, give street and number)

St. Elizabeth's Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

193-01-2130

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 19, 1914

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4208 Barrington Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel Manager

16b. Kind of Business/Industry

Westinghouse

17. Father's Name (First, Middle, Last)

Peter Jacob Hartung

18. Mother's Name (First, Middle, Maiden Surname)

Marie Schaffer

19a. Informant's Name/Relationship (Type, Print)

Katherine Hartung/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4208 Barrington Rd Baltimore, MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro-vascular accident

Approximate Interval Between Onset and Death

1 hour

Due to (or as a consequence of):

b. Chronic atrial fibrillation

10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yelena Lipnik MD

29c. License number

052746

29d. Date signed (Month, Day, Year)

NOV. 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yelena Lipnik 720 Maiden Choice Lane Baltimore 21228

31. Date filed (Month, Day Year)

DEC 6 1999

32. Registrar's Signature

Yelena Lipnik

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-342-2020.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

REC 8 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFHG781 3/15/2000 EW

Certificate of Death

Reg. No. 99 38078

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) QUEEN ESTER JOHNSON | | | | 2. Date of Death Month Day Year NOV. 23, 1999 | | 3. Time of Death 12:15am | |
| | 4a. Facility Name (If not institution, give street and number) MANOR CARE HEALTH SERVICES TOWSON | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 916-36-3871 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 59 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6-1-1940 | 9. Birthplace (State or Foreign Country) Florida |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 5203 CRAIG AVE | | | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry HOME MAKER | | |
| 17. Father's Name (First, Middle, Last) NATHANIEL MINDS | | | | 18. Mother's Name (First, Middle, Maiden Surname) EVA WILLIAMS | | | | |
| 19e. Informant's Name/Relationship (Type, Print) LINDA CRUMPTON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5203 CRAIG AVE BALTO, MD 21214 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION | | Date 11-29-99 | | 20c. Location - City or Town, State MARYLAND | | |
| 21. Signature of Funeral Service Licensee W. Howell | | | | 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE BALTO, MD 21209 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Heart Failure Due to (or as a consequence of): b. Cerebrovascular accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Howell | | | | 29c. License number D31464 | | 29d. Date signed (Month, Day, Year) 12/31/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.A. HATHORN MD, 821 N. Entaw St Suite 308 Balt. MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials

DEC 0 0 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38079

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Catherine Octavia Johnson | | | | 2. Date of Death Month Day Year DECEMBER 3, 1999 | | | | 3. Time of Death 11pm | | | | |
| | 4a. Facility Name (If not institution, give street and number) St. Elizabeth Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death n/a | | | | |
| Funeral Director | 5. Social Security Number 218-22-6308 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 29, 1906 | | 9. Birthplace (State or Foreign Country) Md. | | | | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number 4317 Fairfax Road | | | | 10f. Zip Code 21216 | | | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | | | 16b. Kind of Business/Industry Josephite Fathers | | | | | |
| 17. Father's Name (First, Middle, Last) James Small | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Theresa B. Jones Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Fairfax Road Baltimore, Md. 21216 | | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park | | | | 20c. Location - City or Town, State Dec. 9 Baltimore, Md. | | | | | |
| 21. Signature of Funeral Service Licensee Hubert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | | | | | | |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Cardiac Ischemia Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death < 1 hr years | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's dementia Gastrointestinal bleeding | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Cecilia Papad | | | | 29c. License number DQ7541 | | 29d. Date signed (Month, Day, Year) Dec 6, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CIEYHA RAJA, 4367 Hollins Ferry Dr, Baltimore MD -8227 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature Dennis S. Sparks | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

X

State
Registrar

Johnson, Catherine

MILATE

AT

James E. Jones

DEC 6 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38080

AMENDE ITEM #7 & #8 PER FH G778 12/6/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JONAS T. JONES

2. Date of Death

Month

Day

Year

NOVEMBER 30, 1999

3. Time of Death

1:10am

Funeral
Director

4e. Facility Name (If not institution, give street and number)

DULANEY TOWSON HEALTH CARE CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

220-12-6358

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96 90 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

6-13-03 6/13/09

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

713 N. GRANTLEY ST.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4or 5+)

-2-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

PIPE FITTER

16b. Kind of Business/Industry

STEEL

17. Father's Name (First, Middle, Last)

JOHNNY JONES

18. Mother's Name (First, Middle, Maiden Surname)

AMELIA TRAYHAM

19a. Informant's Name/Relationship (Type, Print)

DEIDRA JONES-COPPER(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

713 N. GRANTLEY ST. BALTIMORE, MARYLAND 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS 12-3-99 OWINGS MILLS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jonathan D. Hisner

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dementia

Due to (or as a consequence of):

Diabetes Mellitus

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jonathan D. Hisner

29c. License number

D53642

29d. Date signed (Month, Day, Year)

Nov. 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X/AD M Zhou 3007 E Northern Parkway Baltimore 21214

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

James B. Sparks

Jonas T. Jones

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38081

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEATRICE

KRAUS

2. Date of Death

Month Day Year
DEC. 1 1999

3. Time of Death

12:05AM

4a. Facility Name (If not institution, give street and number)

3601 CLARKS LA, APT. 410

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

273-03-2297

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

8. Date of Birth

FEB. 27, 1917

9. Birthplace (State or Foreign Country)

CZECH.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3601 CLARKS LA, APT. 410

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MERCHANT

16b. Kind of Business/Industry

RESTAURANT SUPPLIES & EQUIPMENT

17. Father's Name (First, Middle, Last)

SHLOIME

POLSTER

18. Mother's Name (First, Middle, Maiden Summa)

MIRIAM

BLAUGRUND

19a. Informant's Name/Relationship (Type, Print)

FREDRICK KRAUS (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6741 STONECUTTER DR. BURKE, VA 22015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON (CHIZUK AMUNO)

Data

12/2/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD. PIKEVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dehydration

Due to (or as a consequence of):

2 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular disease, seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D40371

29d. Date signed (Month, Day, Year)

12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harry Kaplan, MD 90 Printers Mill Rd Suite 126, Owings Mills, MD 21117

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

[Signature]

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38082

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jonathan F. Kuzboski

2. Date of Death
Month Day Year
December 3, 19993. Time of Death
8:30 P.M.Funeral
Director

4a. Facility Name (If not institution, give street and number)

John Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-60-2657

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/29/1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

429 Gusryan Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Francis Kuzboski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Shipley

19a. Informant's Name/Relationship (Type, Print)

Rev. John Kucharczyk/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

689 Ritchie Hwy Severna Park, Maryland 21146

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

12/7/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.
401 S. Chester St. Baltimore, Maryland 21231

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. arrhosis
Due to (or as a consequence of):

5 years

c. leg ulcers
Due to (or as a consequence of):

2 years

d. hyperkalemia

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rene Chatterjee, 600 N. Wolfe Street, Baltimore, MD 21287

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

DEC 6 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38083

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DORIS KNIGHT

2. Date of Death

December 4 1999

3. Time of Death

07:03am

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-05-5002

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 8, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2867 Chesterfield Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Charles W. Dames

18. Mother's Name (First, Middle, Maiden Surname)

Anna Fleichler

19a. Informant's Name/Relationship (Type, Print)

Melvin Dames / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3726 Bonview Avenue Baltimore, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cemetery

Date

12/7/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Timothy Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

LIVER FAILURE

Due to (or as a consequence of):

b.

AUTOIMMUNE HEPATITIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

TEN DAYS

TEN DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Timothy Harman

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

DECEMBER 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PARKWAY, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1224 J. B. B.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38084

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DENA

KADIS

2. Date of Death
Month Day Year

November 25 1999

3. Time of Death

1305 PM

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-42-8769

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JUN. 9, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3900 N. CHARLES STREET #305

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SALESWOMAN

16b. Kind of Business/Industry

DEPARTMENT STORE

17. Father's Name (First, Middle, Last)

PHILIP

DAVID

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

PHILIP KADIS / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 HAMLET HILL ROAD #912 - BALTIMORE, MD 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ARLINGTON CHIZUK AMUNO

Date

11/28/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

b. Empyema

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and DeathTen
Minutes
Ten
Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Alzheimer Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

November 25 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Rosalind C. Gregory-Bass MD

Union Memorial Hospital

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-638-1000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AH

Handwritten signature

DEC 0 8 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38085

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn Evelyn Konradi

2. Date of Death

December 3, 1999

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

Brighton Gardens 7110 Minstral Way

4b. City, Town, or Location of Death

Columbia, MD

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

216-01-2330

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Under 1 Year

Months

9. Under 24 Hrs.

Hours

10. Date of Birth

(Month, Day, Year)

11. Birthplace (State or Foreign Country)

Jul 7, 1914

12. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1142 West Hamburg Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Ownhome

17. Father's Name (First, Middle, Last)

John Rehmer

18. Mother's Name (First, Middle, Maiden Surname)

Jeanette Horn

19a. Informant's Name/Relationship (Type, Print)

Phillip H. Konradi, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4845 Red Hill Way, Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park 12/8

Data

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension
Due to (or as a consequence of):

unkn

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted Living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

051811

29d. Date signed (Month, Day, Year)

December 06, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Ghiore 1120 N. Rolling Rd Baltimore, MD 21228

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

OFF 2 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38086

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Mary Locke

2. Date of Death

Month Day Year

December 1 1999

3. Time of Death

11:45 P.M.

4a. Facility Name (If not institution, give street and number)

Stella Morris at Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214 24 9233

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 22, 1927

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

317 Oak Manor Drive Apt. 104

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Richard Vosler

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Byrd

19a. Informant's Name/Relationship (Type, Print)

Deborah Van Deursen / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13211 Lake Karl Drive Hudson, Florida 34669

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Data

12/7/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Metastatic Adenocarcinoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

hospital

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40854

29d. Date signed (Month, Day, Year)

12/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Riseberg 301 St Paul Pl Baltimore, MD 21202

State
Registrar

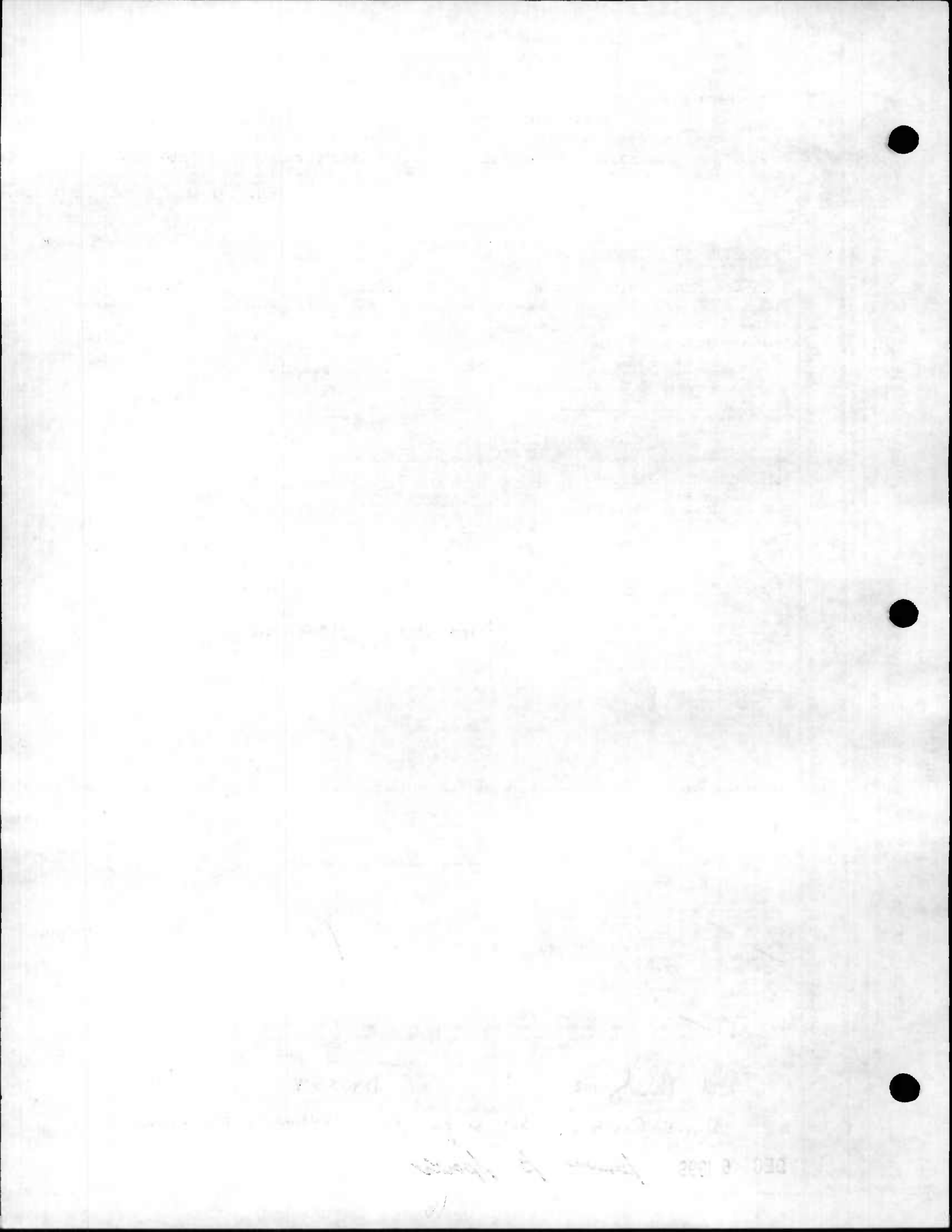
31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38087

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CURTIS LOCKE

2. Date of Death

Month Day Year
DEC 3, 1999 8:50 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

220 24 4290

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
August 4, 1923

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

317 Oak Manor Drive Apt. 104

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

not available

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Coin Dealer

16b. Kind of Business/Industry

Coins

17. Father's Name (First, Middle, Last)

Curtis Hubert Locke

18. Mother's Name (First, Middle, Maiden Surname)

Golden Martin

19a. Informant's Name/Relationship (Type, Print)

Deborah Van Deursen / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13211 Lake Karl Drive Hudson, Florida 34669

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

12/7/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

b. PNEUMONIA, ASPIRATION

Due to (or as a consequence of):

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. RENAL FAILURE

Due to (or as a consequence of):

2 Yrs.

d. DIABETES MELLITUS

Due to (or as a consequence of):

15 Yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CORONARY ARTERY DISEASE

DEMENCIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical ExaminerCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D42680

29d. Date signed (Month, Day, Year)

DEC, 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SABA SZEIK M.D., 9051 BALTIMORE NATIONAL PIKE, BLDG #4, STE E, ELICOTT CITY MD 21042

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38088

Amended Item 19a&19b Per fh G778 12/10/99 Yg

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|--|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Norris B. Lee | | | | 2. Date of Death Month November Day 27 Year 1999 | | 3. Time of Death 12:45 P.M. | |
| 4a. Facility Name (If not institution, give street and number) Genesis Eldercare Spa Creek Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 219 07 4687 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 2, 1920 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Glen Burnie | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 102 North Crain Highway Apt. 907 | | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Hagerstown Express | |
| 17. Father's Name (First, Middle, Last) Walter W. Lee | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lenah Stewart | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara Johnson/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1556 Sulphur Spring Rd. Arbutus, Md. 21227 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. State Veteran Cem. | | Date 12/1/99 | | 20c. Location - City or Town, State Crownsville, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Jerome Francis</i> | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Emphysema</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and Title of Certifier <i>[Signature]</i> | | | | 29c. License number D32036 | | 29d. Date signed (Month, Day, Year) 11/29/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gary J. Spruse 2108 D. North Pine Circle, MD 21019 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38089

AMENDED ITEM #8.9.4a.4c PER FH G778 12/6/99 AH

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NECODA MEEKS | | | | 2. Date of Death Month Nov. Day 30 Year 1999 | | 3. Time of Death 10:55AM | |
| | 4a. Facility Name (If not institution, give street and number) 6402 Gilmore Street | | | | 4b. City, Town or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 238-52-0743 | | 6. Sex M <input type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 5, 1934 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10. Usual Residence of Decedent Maryland | | 11. 10a. State BALTIMORE | | 11. 10b. County WOODLAWN | |
| To Be Completed by Funeral Director | 12. 10c. City, Town or Location WOODLAWN | | 12. 10d. Inside City Limits YES <input type="checkbox"/> No <input type="checkbox"/> | | 13. 10e. Street and Number 6402 Gilmore Street | | 13. 10f. Zip Code 21207 | |
| | 14. 10g. Citizen of What Country? USA | | 15. 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 16. 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 17. 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| To Be Completed by Physician/Medical Examiner | 18. 14. Race - American Indian, Black, White, etc. Specify: Black | | 19. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | 20. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler | | 21. 16b. Kind of Business/Industry General Motors | |
| | 22. 17. Father's Name (First, Middle, Last) ROBERT E. MEEKS | | 23. 18. Mother's Name (First, Middle, Maiden Surname) Maggie McClure | | 24. 19a. Informant's Name/Relationship (Type, Print) MONIQUEE MEEKS / SISTER | | 25. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28150 417 MILLSPY ROAD SHELBY, NORTH CAROLINA | |
| Physician /Medical Examiner | 26. 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 27. 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter Missionary Bapt. Ch. Cem. | | 28. 20c. Location - City or Town, State CROVER, N. CAROLINA | | 29. 21. Signature of Funeral Service Licensee [Signature] | |
| | 30. 22. Name and Address of Facility CHA TOWN-HARRIS #14 5240 REISTERSTOWN ROAD BALTIMORE, MD 21115 | | 31. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. C A PANCREATIS Due to (or as a consequence of): | | 32. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 33. 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 34. 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 35. 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 36. 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 37. 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 38. 28a. Date of Injury (Month, Day, Year) | | 39. 28b. Time of Injury M | | 40. 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 41. 28d. Describe how injury occurred | |
| State Registrar | 42. 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 43. 29b. Signature and title of certifier [Signature] | | 44. 29c. License number 010246 | | 45. 29d. Date signed (Month, Day, Year) 12/1/99 | |
| | 46. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23 CHAS ACARDI DR. OWINGS MILLS, MD 21115 | | 47. 31. Date filed (Month, Day, Year) DEC 6 1999 | | 48. 32. Registrar's Signature [Signature] | | 49. 33. Date of Death 12/1/99 | |

ORIGINAL

117

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State of Maryland / Department of Health and Mental Hygiene 99 38090

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David McKeithen

2. Date of Death

12 / 7 / 99

3. Time of Death

4:20AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Irvington Knolls Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

244-07-0531

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

06/05/1912

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2313 EDMONDSON AVENUE

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CHAUFFEUR

16b. Kind of Business/Industry

TRACTOR TRAILER

17. Father's Name (First, Middle, Last)

COUNCIL

MCKEITHEN

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE MCCORMICK

19a. Informant's Name/Relationship (Type, Print)

ERNESTINE MCKEITHEN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2313 EDMONDSON AVE. BALTO., MD. 21223

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK

Date

12/7/99

20c. Location - City or Town, State

BALTO., MD.

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC

1701 LAURENS ST. BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Myeloma

Due to (or as a consequence of):

b. Acute Renal failure

Due to (or as a consequence of):

c. Carcinoma of prostate

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Yrs

4 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amatin M Naem MD

29c. License number

D15503

29d. Date signed (Month, Day, Year)

12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATIN M NAEM 501 Dolphin St. Balto, MD 21217

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

Bernard B. Spauld

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800.645.6224.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

James E. Jones

DEC 6 1932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38091

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACK

MELENECK

2. Date of Death

Month Day Year
November 25 1999

3. Time of Death

11:05 AM

4a. Facility Name (If not Institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

121-09-7386

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

8. Date of Birth

Month Day Year
DEC. 25, 1904

9. Birthplace (State or Foreign Country)

UNKNOWN

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6430 ELRAY DRIVE #D

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PAINTER

16b. Kind of Business/Industry

HOMES

17. Father's Name (First, Middle, Last)

LOUIS

18. Mother's Name (First, Middle, Maiden Surname)

MELNIKOFF

19. Informant's Name/Relationship (Type, Print)

IDA

(UNKNOWN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BESSIE MELENECK / WIFE

19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6430 ELRAY DRIVE #D - BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WORKMEN CIRCLE CEMETERY

Date

11/28/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Provider

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerosis of coronary Arteries

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature], MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 25, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

William E. KUKA, MD Sinai Hospital 2401 West Belvedere Avenue, Baltimore, Maryland 21215

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

[Signature]

State
Registrar

Meleneck, Jack.

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

DEC 9 6 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38092

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert J. Miller

2. Date of Death

December 3 1999

Day Year

3. Time of Death

0600 Am

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

193 10 9978

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 24, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2719 Norfen Road

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Shipping & Receiving Clerk

16b. Kind of Business/Industry

Paint Corp.

17. Father's Name (First, Middle, Last)

Andrew J. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Mullen

19a. Informant's Name/Relationship (Type, Print)

Linda Fisher / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1041 Old County Road Severna Park, Maryland 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakeview Memorial Park

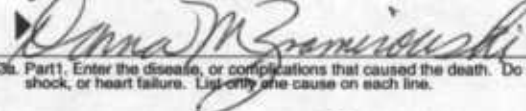
Date

12/6/99

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N. Swarman, House physician

29c. License number

D0054836

29d. Date signed (Month, Day, Year)

Dec Third nineteen ninety nine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARAYINI SIVARAMAN, 10229 BERKSHIRE LANE, ELLICOTT CITY, MD 21042

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

H

DEC 3 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38093

RONNIE MCKNIGHT

AMEND ITEMS: #23 PART I, 27, PER ME Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ronnie D. McKnight Sr. | | | | 2. Date of Death Month Day Year DEC. 2, 1999 | | 3. Time of Death 0852 AM | |
| | 4a. Facility Name (If not institution, give street and number) 131 NORTH BEND ROAD | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218 58 8197 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 47 Yrs. | | 8. Date of Birth (Month, Day, Year) August 28, 1952 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10e. Street and Number 131 North Bend Road | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | 16b. Kind of Business/Industry Plastic Company | |
| | 17. Father's Name (First, Middle, Last) Darrell McKnight | | | | 18. Mother's Name (First, Middle, Maiden Surname) P. Lorraine Russell | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Christina Schroeder / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Blue Jay Court Baltimore, Maryland 21227 | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | Date 12/6/99 | | 20c. Location - City or Town, State Glen Burnie, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHRONIC ALCOHOLISM AND NARCOTISM | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHRONIC ALCOHOLISM AND NARCOTISM | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHRONIC ALCOHOLISM AND NARCOTISM | | | | 24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | |
| | 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number O.C.M.E | | | |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29d. Date signed (Month, Day, Year) DEC. 3, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year) DEC 06 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |
| | 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Handwritten signature

DEC 08 1978

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

M.F.O. G778 12-14-99WR

99 38094

AMEND ITEMS: #23 PART I, 27, 28A-F PER Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--------------------------------|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MICHAEL FRANCIS MEREDITH | | | | | 2. Date of Death Month Day Year November 30, 1999 | | 3. Time of Death 8:55 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 216-72-4320 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 37 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 09-25-62 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County ANNE ARUNDEL | 10c. City, Town or Location PASADENA | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 113 SHARON DRIVE | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES PERSON | | 16b. Kind of Business/Industry AUTO PARTS | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) HAROLD MEREDITH | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH JOHNSTON | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ELIZABETH JOHNSTON MOTHER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 1ST AVENUE, BALTIMORE, MD. 21227 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Date 12-3-99 | | 20d. Location - City or Town, State BALTIMORE, MD | | | |
| | 21. Signature of Funeral Service Licensee <i>Vaughn C. Hu</i> | | | | | 22. Name and Address of Facility CREMATION SERVICES 5151 BALTO. NATL PIKE BALTO. MD. 21229 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11-30-99 | | 28b. Time of Injury UNKNOWN | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | |
| | | | 28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) UNKNOWN | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>J. Pestaner, MD</i> | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 01, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestaner</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature <i>Benita S. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 6 1988
J. L. ...
...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#20-22 PER F.H. G778 12-14-99 J.A.

Certificate of Death

Reg. No. 99 38095

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Meadows

2. Date of Death
Month Day Year

November 23, 1999 1:44 P.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Franklin Square Hospital Center Rosedale Baltimore

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

218-62-2047

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov 5, 1953

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

209 Middleway Road #1A

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Libby Crawford

19a. Informant's Name/Relationship (Type, Print)

Richard Meadows/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

263 S. Ellwood Street Baltimore, MD 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY INC.

Date

12/10/99

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Edward Gregorchik Ronald S. Wade Director

22. Name and Address of Facility CREMATION SOCIETY OF MARYLAND

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 299 FREDERICK RD. BALTIMORE MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

2 years

Due to (or as a consequence of):

b. Morbid Obesity

Due to (or as a consequence of):

c. Arteriosclerotic Coronary Artery Disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Niehoff MD

29c. License number

D0029197

29d. Date signed (Month, Day, Year)

11/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Michael Niehoff 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Benjamin S. Sparks

State
RegistrarDivision of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-2025.

DEC 9 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38096
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Paul H. Nickerson | | 2. Date of Death Month December Day 1 Year 1999 | | 3. Time of Death 16⁰⁰ | |
| 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE, CITY | | 4c. County of Death |
| 5. Social Security Number 015 12 2184 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | 8. Date of Birth (Month, Day, Year) Aug. 2, 1919 | 9. Birthplace (State or Foreign Country) Mass. | |
| Usual Residence of Decedent | | | | | |
| 10a. State Md. | 10b. County Carroll | 10c. City, Town or Location Sykesville | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7200 Third Ave. | | 10f. Zip Code 21784 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1940- If Yes, Give Year or Dates: 1954 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +4 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator | | 16b. Kind of Business/Industry Md. Health Dept. | | | |
| 17. Father's Name (First, Middle, Last) Harry Nickerson | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie W. (unknown) | | |
| 19a. Informant's Name/Relationship (Type, Print) Gladys S. Nickerson (Wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave. A310 Sykesville, Md. 21784 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory, or other place) Rest Haven Mem. Park | | 20c. Location - City or Town, State Frederick, Md. | |
| 21. Signature of Funeral Service Licensee Harry W. Haight | | | 22. Name and Address of Facility Haight Funeral Home & Chapel PA P.O.Box 195 Sykesville, Md. 21784 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 years | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. candida tropicalis fungemia adult respiratory distress syndrome gastrointestinal bleed | | | | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Aimee Zaas MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) December 1, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aimee Zaas, MD Johns Hopkins Hospital 600 N. Wolfe Baltimore, MD 21287 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38097

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NORMAN

J

NEEDLE

2. Date of Death

November 30, 1999

3. Time of Death

2015

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-28-4986

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

AUG. 19, 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6915 OLD PIMLICO RD.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes 2 ☐ No KOREA

If Yes, Give Year or Dates: 1952-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BROKER

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

SIDNEY

B.

NEEDLE

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN

CARP

19a. Informant's Name/Relationship (Type, Print)

MRS. ALICE L. NEEDLE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6915 OLD PIMLICO RD. BALTIMORE, MD 21209

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW FRIENDSHIP

Date

12/2/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Representative

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Intracranial hemorrhage

5 days

Due to (or as a consequence of):

b. Aspiration pneumonitis

5 days

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Justin C. Brown, M.D. Sinai Hospital 2401 W. Belvedere Ave., Balto. Md. 21215

State
Registrar

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

James B. Sparks

Patient Known As Norman Needle
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38098

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEROME NICHOLS

2. Date of Death

NOVEMBER 30, 1999

3. Time of Death

1:15am

4a. Facility Name (If not institution, give street and number)

BRIGHTWOOD NURSING CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-26-2675

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1-8-31

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

HOWARD

10c. City, Town or Location

JESSUP

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7337 CEDAR AVE.

10f. Zip Code

20794

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HEALTH ASSISTANT

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

EMERSON NICHOLS

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN JACKSON

19a. Informant's Name/Relationship (Type, Print)

BERNICE HENRY (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

596-A YALE AVE. BALTIMORE, MARYLAND 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOW RIDGE CEMETERY

Date

12-3-99

20c. Location - City or Town, State

ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

LUNG CANCER

Approximate Interval Between Onset and Death

MONTHS

b.

Due to (or as a consequence of):

SMOKING

YEARS

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D52279

29d. Date signed (Month, Day, Year)

12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Souram H. IBACASUBRAMANIAN 4920 CAMPBELL BLVD MD 21236

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

TECHNICAL REPORT

DEC 8 1983

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38099

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Constance Owens

2. Date of Death

November 24 1999

3. Time of Death

1:40am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris 2300 Dulaney Valley Rd

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

232-09-2064

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Apr 13, 1908

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2300 Dulaney Valley Rd

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

red cross

16b. Kind of Business/Industry

health

17. Father's Name (First, Middle, Last)

Herbert Richards

18. Mother's Name (First, Middle, Maiden Surname)

Cebe

19a. Informant's Name/Relationship (Type, Print)

Mary Constance Tirala/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1144 Halstead Rd Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

b. DEMENTIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

11. 29. 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State
Registrar

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: OWENS, CONSTANCE

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART I, PER MD G778 12-6-99 WR
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death

Reg. No. 99 38100

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: All death certificates have been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|---------------------------------|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) JOSEPH SANTO PIETRO | | 2. Date of Death Month NOV Day 28 Year 1999 | | 3. Time of Death 6:25 PM | |
| 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard |
| 5. Social Security Number 213-09-2131 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) Feb 2, 1911 | | 9. Birthplace (State or Foreign Country) Italy | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 3435 McShane Way | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ironworker | | 16b. Kind of Business/Industry Steel | | | |
| 17. Father's Name (First, Middle, Last) Guiseppe Santopietro | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Bevilacqua | | |
| 19a. Informant's Name/Relationship (Type, Print) Joseph Santopietro Jr. /son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8210 Peach Orchard Rd Baltimore, MD | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State 1999 Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE AZOITEMIA RENAL FAILURE | | | | | Approximate Interval Between Onset and Death 72 Hrs. |
| Due to (or as a consequence of): HYPERTKALEMIA | | | | | 72 Hours |
| Due to (or as a consequence of): METABOLIC ACIDOSIS | | | | | 72 Hours |
| Due to (or as a consequence of): ACUTE RENAL FAILURE | | | | | 72 Hours |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. INSULIN DEPENDENT DIABETES MELLITUS | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Edward H. Schaefer MD. | | 29c. License number D18457 | | 29d. Date signed (Month, Day, Year) NOV. 29, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARD SCHAEFER MD. HOWARD COUNTY GENERAL HOSP. | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38101

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Frederick William Putsche, Sr. 2. Date of Death Month Day Year December 2, 1999 3. Time of Death 7:35 PM

4a. Facility Name (If not institution, give street and number)

Chesapeake Hospice House

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-05-8863

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV 22, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

517 Laclair Avenue

10f. Zip Code

21090

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1944/1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

Frederick J. Putsche

18. Mother's Name (First, Middle, Maiden Surname)

Mary McCormick

19a. Informant's Name/Relationship (Type, Print)

John F. Putsche/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

466 Shane Creek Rd., Columbus, MT 59019

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 12/3/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Md., Inc. 299 Frederick Rd. Baltimore, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer

Due to (or as a consequence of):

Cerebrovascular accident

Due to (or as a consequence of):

Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending Investigation

☐ Accident

☐ Suicide

☐ Homicide

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

GAYATRI NIMMA GADDA

29c. License number

D39041

29d. Date signed (Month, Day, Year)

Dec 03 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GAYATRI NIMMA GADDA 1600 S. Crain Highway

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38102

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michael Jerome Pines | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 10:40 AM | |
| | 4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-58-7256 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 47 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOV 13, 1952 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1616 Northbourne Road | | | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | | 16b. Kind of Business/Industry Steel Industry | |
| 17. Father's Name (First, Middle, Last) James E. Pines | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian M. Weddington | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Faye E. Pines/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Northbourne Road Baltimore, MD 21239 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 12/6/99 | | 20c. Location - City or Town, State Baltimore, MD |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. AIDS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death Unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Alice B. Heister, M.D. | | 29c. License number D05055 | | 29d. Date signed (Month, Day, Year) 12-4-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alice Heister 630 W. Fayette St. (Walter Carter Center) Balt. MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38103

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Petticrew

2. Date of Death

November 27, 1999

3. Time of Death

1313

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-36-8580

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Oct. 30, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 MAIDEN CHOICE LANE APT BR 320

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

MARYLAND MOTOR

VEHICLE ADMINISTRATION

17. Father's Name (First, Middle, Last)

HARRY DUNCAN HORNER

18. Mother's Name (First, Middle, Maiden Summa)

ESTELLE STEWART

19a. Informant's Name/Relationship (Type, Print)

N. EDWARD ORNDORFF (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

730 KINDIG RD., LITTLESTOWN, PA 17340

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

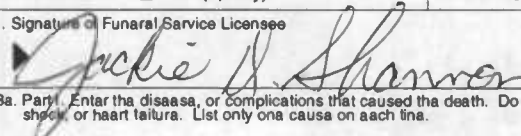
METRO CREMATORY

Date

11/29/99 CATONSVILLE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

4107 Wilkens Avenue
HUBBARD FUNERAL HOME Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Larry Harkins

29c. License number

H0051339

29d. Date signed (Month, Day, Year)

November 27, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. Larry Harkins 5401 Old Ct. Rd. Randallstown MD 21133

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5053.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 8 1938
JAMES B. HARRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38104

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STONEWALL J. PARKER, JR.

2. Date of Death
Month Day Year

December 1, 1999

3. Time of Death

11:30 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VA MEDICAL CENTER, FORT HOWARD MD 21052

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

5. Social Security Number

219-18-3719

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7-5-23

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1810 APPLETON ST.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
-12-College (1-4 or 5+)
-1-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

STONEWALL J. PARKER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ALBERTA PARKER

19a. Informant's Name/Relationship (Type, Print)

EDNA PARKER(FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1123 N. MONROE ST. BALTIMORE, MARYLAND 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRISON FOREST VETERANS 12-7-99 OWINGS MILLS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dorothy Hector CFS

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Pancreatic Carcinoma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Andrew Mrowiec M.D.

29c. License number

247804

29d. Date signed (Month, Day, Year)

12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW MROWIEC, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Genevieve S. Sparks

State
Registrar

AVA: Parker, Stonewall
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 22a or 22a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 6 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38105

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Frances N. Rutter | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 1:00 AM | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| 5. Social Security Number 228-34-1281 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 3-13-1932 | |
| 9. Birthplace (State or Foreign Country) Virginia | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 1520 West Mt. Royal Ave. | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U. S. A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Register Nurse | | 16b. Kind of Business/Industry State Of Maryland | |
| 17. Father's Name (First, Middle, Last) David P. Nickels | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie Cox | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ms Kathryn L. Rutter (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Lake Montebello Terrace, Baltimore, Maryland | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | Data 12-6-99 | | 20c. Location - City or Town, State Towson, Maryland | |
| 21. Signature of Funeral Service Licensee Wallace S. Brooke, Jr. | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D43725 | | 29d. Date signed (Month, Day, Year) 12/6/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MATMOOD 201-109 Back River Neck Rd Baltimore MD 21221 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature [Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.


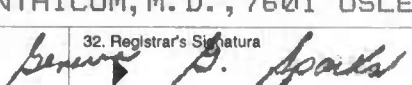
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38106

Certificate of Death

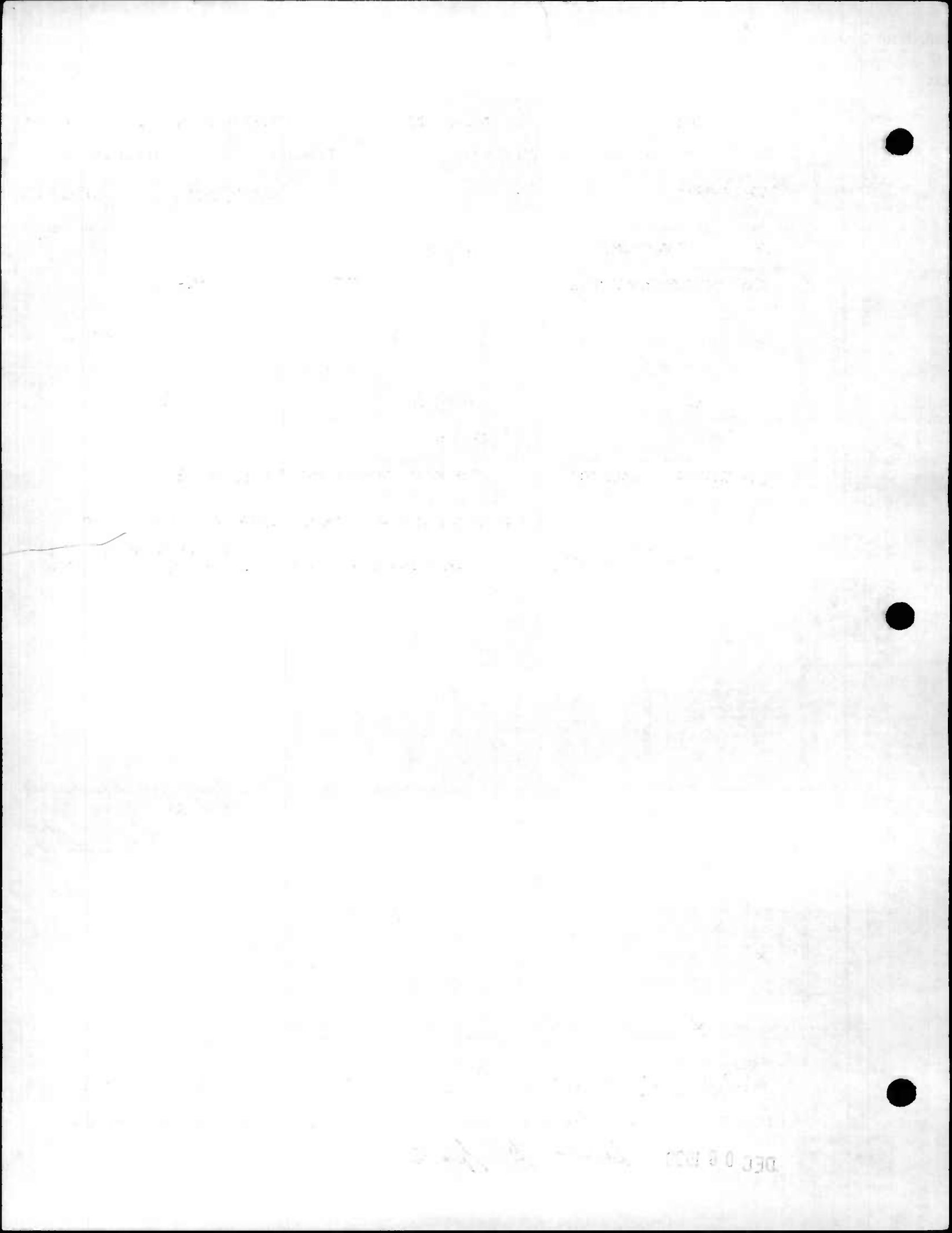
Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) IDA RABINOWITZ | | 2. Date of Death Month NOVEMBER Day 28 Year 1999 | | 3. Time of Death 2:56 AM |
| | 4a. Facility Name (If not Institution, give street and number) Saint Joseph Medical Center | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 340-12-6974 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) MAY 7, 1921 | | 9. Birthplace (State or Foreign Country) LITHUANIA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedant | | | | |
| | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 4331 CRESTHEIGHTS ROAD | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE | | |
| | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry OWN HOME | | |
| | 17. Father's Name (First, Middle, Last) (UNKNOWN) | | 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) | | |
| | 19a. Informant's Name/Relationship (Type, Print) RENA SHAPIRO / DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 NERAK ROAD - BALTIMORE, MD 21208 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) AGUDAS ACHIM ANSHE SFARD | | 20c. Location - City or Town, State 11/29/99 ROSEDALE, MD |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA | | | | Approximate Interval Between Onset and Death |
| | Immediata Causa (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. RENAL FAILURE | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Time of Injury M | | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier  | | 29c. License number D31826 | | 29d. Date signed (Month, Day, Year) 11-28-99 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature  | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38107

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Virginia Rouse

2. Date of Death

December 5, 1999

3. Time of Death

4:30pm

4a. Facility Name (If not institution, give street and number)

8811 Flagstone Drive

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

273-24-6366

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 6, 1923

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8811 Flagstone Drive

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Buckler

18. Mother's Name (First, Middle, Maiden Surname)

Nellie

19a. Informant's Name/Relationship (Type, Print)

Mr. Joseph Rouse (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8811 Flagstone Drive Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Mem. Park

Date

12/8/99

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

► Paige Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel, PA (Box 195)
Sykesville, MD 21784 (410)-795-140023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Metastatic Lung Cancer

Due to (or as a consequence of):

b.

Primary Squamous Carcinoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6 months

> 6 months

Part II. Other etiological conditions contributing to death but not resulting in the underylying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

► Patrick A. Turner

29c. License number

D 20806

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK A. TURNER 1425 LIBERTY RD ELDERSBURG MD 21784

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

DEC 01 1953
[Handwritten signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38108

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|---------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) Margaret V Reichert | | | | 2. Date of Death Month Nov Day 29 Year 1999 | | 3. Time of Death 9:20 PM | |
| 4a. Facility Name (If not institution, give street and number) St. Agnes Health Care | | | | 4b. City, Town, or Location of Death Baltimore Md | | 4c. County of Death n/a | |
| 5. Social Security Number 213-14-4915 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | 8. Date of Birth (Month, Day, Year) Aug. 14, 1921 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5015 Wilkens Avenue | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Ownhome | |
| 17. Father's Name (First, Middle, Last) James DeLauder | | | | 18. Mother's Name (First, Middle, Maiden Summa) Mary E. Green | | | |
| 19a. Informant's Name/Relationship (Type, Print) Daniel E. Reichert, Jr. / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5015 Wilkens Avenue, Baltimore, Maryland 21228 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Data 12/2/99 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Exacerbation of chronic obstructive pulmonary disease 7 days Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, renal failure, Coronary Artery Disease, Stroke | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Chulanto Kaulahe, MD | | | | 29c. License number D46704 | | 29d. Date signed (Month, Day, Year) Nov 29, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTOMBO KANKORDE, ST AGNES HOSPITAL, BLT, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature James B Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 502A.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Handwritten signature

DEC 8 1933

WINE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-1234.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|---|---|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MICHAEL ANTHONY RAYMOND | | | | 2. Date of Death Month Day Year DECEMBER 1, 1999 | | 3. Time of Death 1845 PM | |
| | 4a. Facility Name (If not institution, give street and number) 3600 BLOCK OF HAYWARD AVENUE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 213-98-7636 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 18 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG 12 1981 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2809 VIRGINIA AVE. APT. B4 | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED | | 16b. Kind of Business/Industry NA | | |
| 17. Father's Name (First, Middle, Last) MICHAEL A. CHASE | | | | 18. Mother's Name (First, Middle, Maiden Surname) CHRISTINA RAYMOND | | | | |
| 19a. Informant's Name/Relationship (Type, Print) CHRISTINA RATCHFORD-MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 VIRGINIA AVE. APT. B4 BALTO., MD 21215 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | 20c. Date 12-8-99 | | 20d. Location - City or Town, State RANDALLSTOWN, MD | | |
| 21. Signature of Funeral Service Licensee Phyllis B. Harris | | | | 22. Name and Address of Facility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month/Day Year) 12/1/99 | | 28b. Time of Injury 1820 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | 28d. Describe how injury occurred Subject shot | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3600 Blk. Hayward Ave | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Sam Lefebvre | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DECEMBER 2, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. P. W. C. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature Benjamin B. Sparks | | | | | | |

DEC 28 1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38110

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA RANDALL

2. Date of Death

Month
11Day
17Year
99

3. Time of Death

11:37am

4a. Facility Name (If not institution, give street and number)

3132 HARVIEW AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

238-64-3194

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

FEB. 9, 1942

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3132 HARVIEW AVENUE

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HEALTH PROVIDER

16b. Kind of Business/Industry

HEALTH

17. Father's Name (First, Middle, Last)

JOHNNIE JONES SR.

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE KORNEGAY

19a. Informant's Name/Relationship (Type, Print)

ADRIENNE RANDALL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 ATHOL GATE LANE APT C BALTO., MD 21229

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

11-22-99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

GARY P. MARCH PER DVR

22. Name and Address of Facility

GARY P. MARCH FUNERAL HOME PA.

270 FREDHILTON PASS BALTO., MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Hypertension, Hypercholesterolemia

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N/A

29c. License number

D43574

29d. Date signed (Month, Day, Year)

12-3-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIL M. SIEGEL, MD 4538 Edmondson Ave, Baltimore MD 21229

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

Bennett P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or initials

DEC 6 1999

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38111

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38112

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANTHONY WILLIAM SCALJON | | | | 2. Date of Death Month Day Year December 5, 1999 | | 3. Time of Death 9:52 PM | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 215-09-0091 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr. 17, 1912 | |
| | Usual Residence of Decedent | | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Pakerville | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8820 Walther Blvd. # 4207 | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur | | 16b. Kind of Business/Industry Self employed | | | | |
| 17. Father's Name (First, Middle, Last) William Scaljon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Esther Vickos | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Esther Samios/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Horseshoe Cr. Lutherville, Md. 21093 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cemetery | | 20c. Location - City or Town, State 12/9/99 Woodlawn, MD. | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Approximate Interval Between Onset and Death 30 minutes | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 20053345 | | 29d. Date signed (Month, Day, Year) 12/5/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Krikanda MD, 900 Franklin Square Drive Baltimore Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 0003.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38113

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Ann Smith

2. Date of Death

December 02, 1999

3. Time of Death

11:15 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Brightwood-Genesis Elder Care

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore Co.

5. Social Security Number

219-30-5886

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 04, 1928

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

515 Brightfield Road

10f. Zip Code

21022

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

09

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles L. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Anna H. Johnson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dorothy Moore(Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

340 Greendale Road York, PA. 17403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Memorial Park

Date

12/06/1999

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

Michael J. Smith

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

b. Cerebral vascular accident

Due to (or as a consequence of):

2 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of the rectum

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Allen Cool, M.D.

29c. License number

D34650

29d. Date signed (Month, Day, Year)

12-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFFREY ALLEN COOL, M.D. BRIGHTWOOD-GENESIS ELDER CARE, LUTHERVILLE, MD

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

James S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 3 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38114**
Certificate of Death Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bernard Sanders | | | | 2. Date of Death Month December Day 3 Year 1999 | | 3. Time of Death 21:48pm | |
| | 4a. Facility Name (If not institution, give street and number) Mercy Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death City | |
| Funeral Director | 5. Social Security Number 147-12-7990 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 5, 1909 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1213 Light Street | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | | 16b. Kind of Business/Industry Car Parts | |
| 17. Father's Name (First, Middle, Last) Jacob Sanders | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ceciley Rome | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Anna-Marie Evans | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Garrett Rd. Apt. A304 Upper Darby, PA 19082 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 12/6/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Dawn F. McDonald | | | | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 12 hours |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency Vascular Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Karen A. Kuzick, MD | | 29c. License number D40744 | | 29d. Date signed (Month, Day, Year) December 3, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.A. Kuzick Mercy Hospital 30 St. Paul Pl, Balt, MD 21202 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature [Signature] | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38115

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Reginald

Spencer

2. Date of Death
Month Day Year

December 2 1999

3. Time of Death

2250

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

104-34-4851

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth
(Month, Day, Year)

DEC 23, 1944

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28 Allegheny Avenue Apt. 2708

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Entrepreneur

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

Bruno Szczepanski

18. Mother's Name (First, Middle, Maiden Surname)

Lily Wysowski

19a. Informant's Name/Relationship (Type, Print)

Ellen Spencer/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11769 Lone Tree Ct. Columbia, MD 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/4/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Renal failure

Approximate Interval Between Onset and Death

one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pneumonia

three weeks

Chronic lymphocytic leukemia

ten years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dawn F. McDonald

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

December 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abenaa Brewster Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

DEC 06 1999

32. Registrar's Signature

Dawn F. McDonald

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2028.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38116

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|--------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BESSIE SINGER | | 2. Date of Death Month NOVEMBER Day 29 Year 1999 | | 3. Time of Death 8:24 PM |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 220-34-7226 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) DEC. 18, 1915 | | 9. Birthplace (State or Foreign Country) MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 6404 APOLLO DRIVE #C | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | |
| | 17. Father's Name (First, Middle, Last) MAX PEREL | | 18. Mother's Name (First, Middle, Maiden Surname) MARY HELMAN | | |
| | 19a. Informant's Name/Relationship (Type, Print) LARRY SINGER / SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 APOLLO DRIVE #C - BALTIMORE, MD 21209 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE NEISEN | | Date 12/1/99 |
| | 20c. Location - City or Town, State ROSEDALE, MD | | 21. Signature of Funeral Service Licensee <i>Michael Druger</i> | | |
| 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiopulmonary Arrest</i> Due to (or as a consequence of): b. <i>Atherosclerotic Disease</i> Due to (or as a consequence of): c. <i>Hypertension</i> Due to (or as a consequence of): d. <i>Dementia</i> | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospitel: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <i>Joyce Y. Gross MD</i> | | 29c. License number D23985 | | 29d. Date signed (Month, Day, Year) 11/30/99 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOYCE GROSS, M.D. 6569 N. CHARLES ST. #411 TOWSON, MD 21204 | | | | |
| | 31. Data filed (Month, Day, Year) DEC 06 1999 | | | | |
| State Registrar | 32. Registrar's Signature <i>B. Sparks</i> | | | | |

ORIGINAL

James H. Jones

DEC 8 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38117

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RACHEL SALZMAN | | | | 2. Date of Death Month NOV. Day 26 Year 1999 | | 3. Time of Death 9:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 3409 COURTLEIGH DRIVE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 214-22-5408 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs., last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 14 1911 | | |
| | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3409 COURTLEIGH DRIVE | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME | | | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) NATHAN BLACK | | | | 18. Mother's Name (First, Middle, Maiden Surname) MIRIAM SMULIAN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) LAWRENCE SALZMAN /SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 CROSS TIMBER WAY FREDERICK, MD. 21702 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HAR ZION TIFERETH ISRAEL | | Date NOV. 28/99 | | 20c. Location - City or Town, State ROSEDALE, MD. | |
| 21. Signature of Funeral Service Licensed | | | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardio Renal b. Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d. | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D-09383 | |
| 29d. Date signed (Month, Day, Year) November 26, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore MD 21210 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | 32. Registrar's Signature | | | | | |

ORIGINAL

Handwritten signature

DEC 6 1939

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38118

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | |
|--|--|--|--------------------------------|-----------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) Betty Suter | | 2. Date of Death Month 11 Day 28 Year 99 | | 3. Time of Death 21:45 | |
| 4a. Facility Name (If not institution, give street and number) St. Agnes Hosp. | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| 5. Social Security Number 218-36-1186 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar. 5, 1938 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |

Funeral
Director

To Be Completed by Funeral Director

| | | | | | |
|---|--|---|--|---|--|
| 10a. State Maryland | | 10b. County n/a | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 350 South Smallwood Street | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Ownhome | | | |
| 17. Father's Name (First, Middle, Last) Daniel Fogarty | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Violette Baker | | |
| 19a. Informant's Name/Relationship (Type, Print) Harold W. Brittingham / Nephew | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Reams Court, Westminster, Maryland 21158 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Mem. Gardens | | 20c. Location - City or Town, State 12/01/99 Marriottsville, Md. | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 | | | |

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

| | | |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arrest / Pulm. arrest Due to (or as a consequence of): MI / P.E. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Coagulopathy. Sepsis Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 20-30 min |
|---|--|--|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Laryngeal Cancer, s/p Chemo Tx
End stage COPD, prolonged
Unresponsiveness**

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?
☒ Yes ☐ No

Hospital: ☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Dr. Aradi, MD

P19525

11/28/99

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

**900 S. Caton Avenue
Baltimore, Md. 21229**

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DEC 6 1999

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

DEC 3 1983

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38119

| | | | | | | | | | | |
|--|---|--|---|--------------------------------|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) AHMED SOLOMON | | | | 2. Date of Death Month Day Year DEC. 3, 1999 | | 3. Time of Death 1737 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | | | |
| Funeral Director | 5. Social Security Number 138-90-6319 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 34 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11-15-1965 | | 9. Birthplace (State or Foreign Country) Saudi Arabia | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 2400 E. Fayette Street | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? Saudi Arabia | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Proctor Gamble | | | | |
| | 17. Father's Name (First, Middle, Last) Abubakor Solomon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Aminah Ahmed | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Fawzi Alsomaly- Cousin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4404 Loch Raven Blvd Baltimore, Md 21218 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Family Plot | | 20c. Location - City or Town, State 12-9-99 Saudia, Arbia | | | | | |
| | 21. Signature of Funeral Service Licensee Gladys wanes | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. gunshot Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| Division of Vital Records, P.O. Box 68760, | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12/3/99 | | 28b. Time of Injury 11642 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject Shot. | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Bar ; 2400 East Fayette Street; Baltimore, Md | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier J. Pestauer, M.D. | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 4, 1999 | | | |
| State Registrar | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Joseph Pestauer 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature B. Spauls | | | | | | | |

Handwritten signature

DEC 06 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38120

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) HOMER STRAW | | | | 2. Date of Death Month 12 Day 2 Year 99 | | 3. Time of Death (10:20 PM) | |
| 4a. Facility Name (If not institution, give street and number) Good Samaritan Nursing Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 558-24-8113 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 18, 1920 | 9. Birthplace (State or Foreign Country) New Hampshire |
| Usual Residence of Decedent | | | | | | | |
| 10e. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Parkville | | 10d. Inside City Limits 1 Yes 2 No | |
| 10e. Street and Number 8604 Saddler Road | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | 16b. Kind of Business/Industry Illinois State Government | |
| 17. Father's Name (First, Middle, Last) Archie D. Straw | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beatrice V. Aldrich | | | |
| 19e. Informant's Name/Relationship (Type, Print) Mrs. Sarah Ann Esther Straw/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 Saddler Road Parkville, Maryland 21234 | | | |
| 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park | | Date 12/6/99 | | 20c. Location - City or Town, State Parkville, Maryland | |
| 21. Signature of Funeral Service Licensee Timothy Harman | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): VASCULAR DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 YEARS | | | | | | Approximate Interval Between Onset and Death 2 DAYS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | | | | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | |
| 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier James P. Richardson MD | | | | 29c. License number 027394 | | 29d. Date signed (Month, Day, Year) 12/3/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JAMES P. RICHARDSON MD 5601 LOCK RAVEN BLVD, BALTIMORE MD 21239 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | | 32. Registrar's Signature Gene G. Smith | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38121

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|------------------------------------|---|---|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jeffrey J. Schmidt | | | | | 2. Date of Death Month Day Year November 28, 1999 | | 3. Time of Death 3:51 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) 1660 Furnace Drive | | | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel | | | |
| Funeral Director | 5. Social Security Number 217 62 7949 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 17, 1961 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Glen Burnie | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1660 Furnace Drive | | | | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? U.S. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inventory Purchaser | | | 16b. Kind of Business/Industry Chicago Metallic | | | |
| 17. Father's Name (First, Middle, Last) Christian F. Schmidt Jr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosemary F. Agro | | | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Doreen Schmidt / Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1660 Furnace Drive Glen Burnie, Maryland 21060 | | | | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | | Date 12/1/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Cell Carcinoma, metastatic to lung and brain Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 7 mos | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number D42979 | | 29d. Date signed (Month, Day, Year) 11/30/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe Street Baltimore MD 21287 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38122

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bertha Shea | | | | 2. Date of Death Month Day Year November 28 1999 | | 3. Time of Death 7:05 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Harbor Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212 03 2203 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 16, 1916 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Linthicum | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 919 Lynview Avenue | | | | 10f. Zip Code 21090 | | 10g. Citizen of What Country? U.S. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry Book Company | | |
| 17. Father's Name (First, Middle, Last) Barnard J. Drane | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Gossman | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gloria Barnstorf | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5229 - 6th Street Baltimore, Maryland 21225 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. State Veteran Cem. | | Date 12/1/99 | | 20c. Location - City or Town, State Crownsville, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Acute Myocardial Infarction Due to (or as a consequence of): b. Acute Congestive Heart Failure Due to (or as a consequence of): c. Severe Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): d. Pulmonary Emphysema | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Pneumonia 2 weeks ago | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D09732 | | 29d. Date signed (Month, Day, Year) 11/30/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 42110 H STREET BALTO, MD. 21225 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 9 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38123**
Certificate of Death Reg. No.

| | | | | | | | | |
|---|--|--------------------------|---|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE EDWARD TALLEY | | | | 2. Date of Death Month DEC. Day 2 Year 1999 | | 3. Time of Death 4:47 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) JOSEPH Richey House | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 258-22-7699 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC. 15, 1919 | 9. Birthplace (State or Foreign Country) GA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3419 DOLFIELD AVE | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator | | 16b. Kind of Business/Industry SPARROWS PT. | | |
| 17. Father's Name (First, Middle, Last) EDWARD TALLEY | | | | 18. Mother's Name (First, Middle, Maiden Surname) HATTIE BELL | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JACQUELINE COATES | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 734 YALE AVE BALTO. MD. 21229 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN Cem | | Date 12-8-99 | | 20c. Location - City or Town, State BALTO. MD |
| 21. Signature of Funeral Service Licensee Phyllis B. Harris | | | | 22. Name and Address of Facility March Funeral Home West Inc 4300 Wabash Ave. Balto Md 21215 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinoma LUNG. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 11 mos. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 11 mos. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice. | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Robert C. Irwin MD | | 29c. License number D08900 | | 29d. Date signed (Month, Day, Year) 12-2-99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert C. Irwin MD 828 N. Eutaw St. Balto Md 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | 32. Registrar's Signature Benjamin B. Sparks | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE JOURNAL OF THE

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38124

| | | | | | | | | | |
|---|---|--|---|--------------------------------|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DERRICK B. THOMAS | | | | 2. Date of Death Month Day Year NOV. 29, 1999 | | 3. Time of Death 1825 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 531 WILDWOOD PARKWAY | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 213-62-0618 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 44 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 01-12-55 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 531 WILDWOOD PARKWAY | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (1-4 or 5+) 1 YR | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CREDIT COLLECTOR | | 16b. Kind of Business/Industry CREDIT | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) AUGUSTUS D. KNOX | | | | 18. Mother's Name (First, Middle, Maiden Surname) LEANNA BOWSER | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) WILLIAM THOMAS BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 WILDWOOD PARKWAY, BALTIMORE, MD. 21229 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CREMATION | | Data 12-4-99 | | 20c. Location - City or Town, State BALTIMORE, MD | | |
| | 21. Signature of Funeral Service Licensee Vaughn C. H. | | 22. Name and Address of Facility CREMATION SERVICES 6151 BALTO. NATL PIKE, BALTO. MD. 21229 | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month/Day/Year) Nov 11-29-99 | | 28b. Time of Injury 1820 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred self-inflicted gunshot wound |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 531 Wildwood Pkwy Baltimore, Md | | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Dennis J. Chute, MD | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 30, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| AH | 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

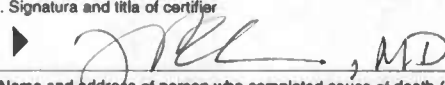
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38125

| | | | | | | | | | | | |
|--|---|---------------------------|---|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETH HANNAH VALINSKY | | | | | 2. Date of Death Month Day Year December 1 1999 | | 3. Time of Death 13:20 | | | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 220-36-3046 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 3, 1940 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10a. State MD | | 10b. County N/A | | 10e. Street and Number 3031 FALLSTAFF ROAD #206C | | | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME | | | 16b. Kind of Business/Industry OWN HOME | | | |
| 17. Father's Name (First, Middle, Last) MICHAEL BERNHARDT | | | | | 18. Mother's Name (First, Middle, Maiden Surname) FRIEDA BARON | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERT VALINSKY / HUSBAND | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3031 FALLSTAFF ROAD #206C - BALTIMORE, MD 21209 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH JACOB CEMETERY | | | Data 12/2/99 | | 20c. Location - City or Town, State FINKSBURG, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Right subdural hematoma and right Due to (or as a consequence of): intra cerebral hemorrhage b. Brain herniation Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | 29b. Signature and title of certifier  MD | | 29c. License number RES 000 | | 29d. Date signed (Month, Day, Year) December 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie Park, MD Sinai Hospital 2401 Belvedere 21215 Baltimore, Maryland | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | | | | 32. Registrar's Signature  | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38126

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD J. WEIDNER

2. Date of Death

Nov 30 1999

3. Time of Death

7:00 A.M.

4a. Facility Name (If not institution, give street and number)

3104 FOSTER AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-42-2499

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 3, 1943

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3104 FOSTER AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

TOW MOTOR OPERATOR

16b. Kind of Business/Industry

WAREHOUSE

17. Father's Name (First, Middle, Last)

EDWARD J. WEIDNER

18. Mother's Name (First, Middle, Maiden Surname)

AGNES KRASKI

19a. Informant's Name/Relationship (Type, Print)

DIXIE WEIDNER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3104 FOSTER AVE BALTIMORE, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SAC. HEART OF JESUS

Date

DEC 3 1999

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SKARDA FH. 3218 HUDSON ST. BALTO. MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

b. Arteriosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

211150

29d. Date signed (Month, Day, Year)

12/2/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Part I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38127

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jacqueline Williams | | | | 2. Date of Death Month Day Year 12 03 99 | | 3. Time of Death 7:30am | |
| | 4a. Facility Name (If not Institution, give street and number) 5609 Lothian Road | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 217-34-7334 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 59 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 08 07 40 | 9. Birthplace (State or Foreign Country) M.D. | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County NA | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 5220 York Road | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) na | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur | | 16b. Kind of Business/Industry Self Employed | | | |
| 17. Father's Name (First, Middle, Last) Elmer Marable | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Johnson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Renee Montgomery-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Ashburton St. Baltimore Md 21216 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State 12/6/99 Randallstown, Md | | |
| 21. Signature of Funeral Service Licensee Reanne H. Thompson | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ca of uterus Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CVA - yrs. ago Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA - yrs. ago | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Michael G. Hayes, MD | | | | 29c. License number D 02290 | | 29d. Date signed (Month, Day, Year) 12/3/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Linden Ave. BALTO Md 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature Denise B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

0001 0 0 000

Wash. D. C. 11/1/1918

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38128

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen B. Young

2. Date of Death

November 29 1999 230 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Colonial Manor

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

5. Social Security Number

263-51-8425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 5, 1903

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

639 Main Street

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

George Burris

18. Mother's Name (First, Middle, Maiden Surname)

Doris

unknown

19a. Informant's Name/Relationship (Type, Print)

Margaret Evans

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1700 Bolton Street Baltimore, Md. 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Dec. 4

20c. Location - City or Town, State

Brooklyn, Md.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Thrombosis

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

sudden

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D15872

29d. Date signed (Month, Day, Year)

November 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harold BOB MD 25 Main St. Reisterstown 21136

31. Date filed (Month, Day, Year)

DEC 6 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Helen Young
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38129

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) Pauline Townsend Alberson | | | | 2. Date of Death Month November Day 17 Year 1999 | | 3. Time of Death 11:00 PM | |
| 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | |
| 5. Social Security Number 217-10-8237 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 8, 1917 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2125 Church Creek Road | | | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? US | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) James L. Townsend | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Tobat | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pamela S. Gillan Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3619 Cinnamon Lane Linkwood, Maryland 21835 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Old Trinity Churchyard | | Date 11/22/99 | | 20c. Location - City or Town, State Church Creek, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Cerebrovascular accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 60 hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D-47924 | | 29d. Date signed (Month, Day, Year) 11-18-99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NOMAN THANNY 300 AURORA STREET CAMBRIDGE MD 21613 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pauline Alberson told Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Stanley Almony

2. Date of Death

November 18 1999

3. Time of Death

1:45 P.M.

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

216-28-4357

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 25, 1931

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

77 WASHINGTON LANE

10f. Zip Code

21157

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

GROUND'S MAN

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

CARROLL ALMONY

18. Mother's Name (First, Middle, Maiden Surname)

CLARA MILLER

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH DUVAL/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

77 Washington Lane, Westminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CARROLL CREMATORY 11/19/99

Date

20c. Location - City or Town, State

HAMPSTEAD, MD

21. Signature of Funeral Service Licensee

James L. Shaw

22. Name and Address of Facility

MYERS FUNERAL HOME, 91 WILLIS STREET
WESTMINSTER, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Chronic obstructive pulmonary disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

5 ☐ Pending investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Robert Titapi M.D.

29c. License number

40525

29d. Date signed (Month, Day, Year)

November 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Titapi M.D. 200 Memorial Avenue, Westminster, MD 21157

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Barbara A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

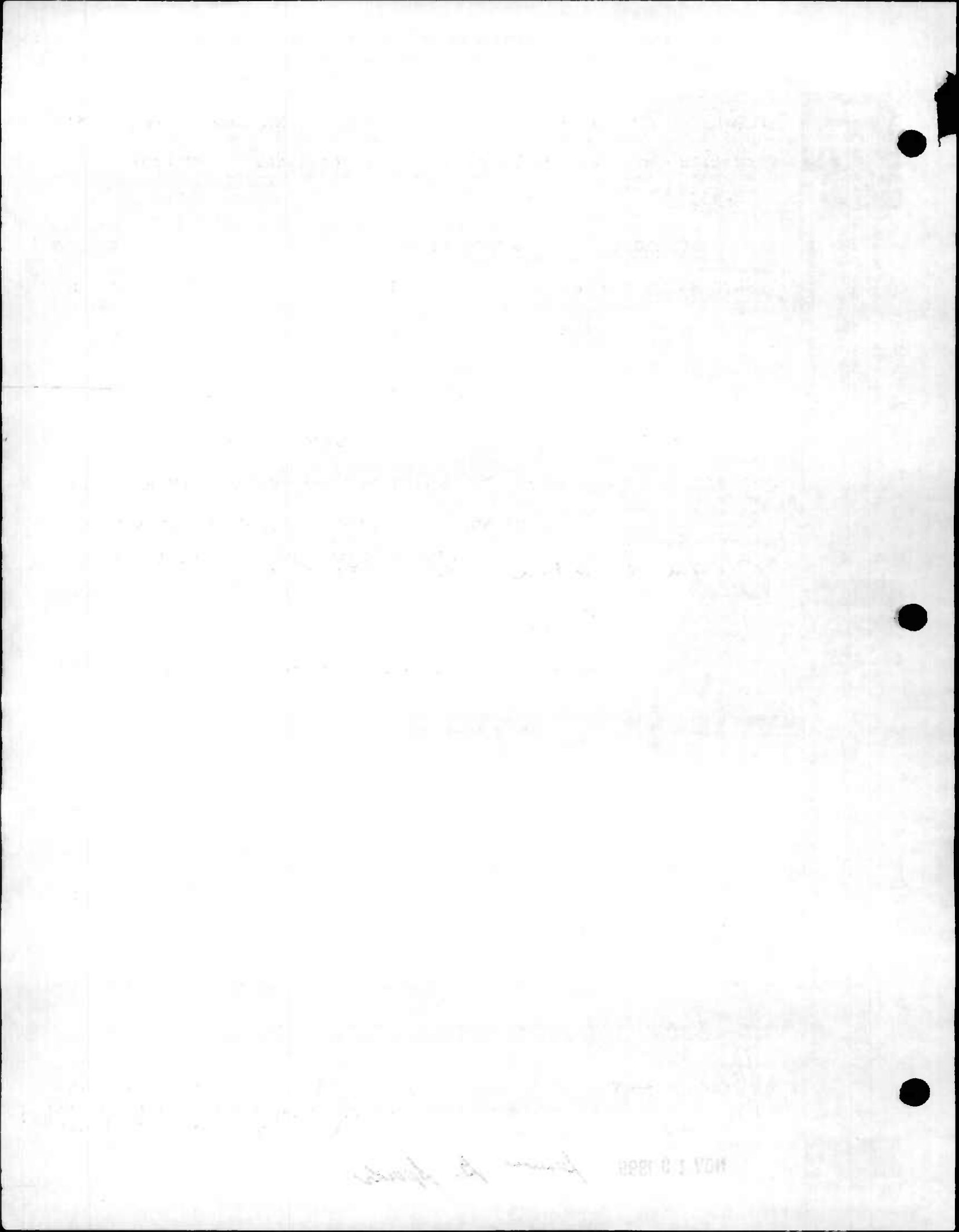
permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38131

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARIAM ABDALLA

2. Date of Death

Month 11 Day 23 Year 99

3. Time of Death

1508

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

NONE

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 11-23-99

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11235 OAKLEAF DR. #816

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Yusuf Aden

18. Mother's Name (First, Middle, Maiden Surname)

Nadia Abdalla

19a. Informant's Name/Relationship (Type, Print)

Yusuf Aden - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11235 OAKLEAF DR. #816 Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington

Date

11-24-99

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

Shane M. Matz

22. Name and Address of Facility

UNIVERSAL mortuary Inc.
411 Kennedy St. N.W., WASH, D.C.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Insufficiency

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 2 hours

b. Extreme Immaturity

Due to (or as a consequence of):

~ 2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Matthew Picard, MD

Attending Physician

29c. License number

Maryland 00050522

29d. Date signed (Month, Day, Year)

11/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Picard, MD; Holy Cross Hospital, Neonatology

1500 Forest Glen Rd.

Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

NOV 26 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text at the top right, possibly a date or reference number.

Handwritten text in the upper middle section.

Handwritten text on the left side, possibly a list or notes.

Large block of handwritten text in the middle section, appearing to be a letter or report.

Handwritten text in the lower middle section, possibly a signature or closing.

Handwritten text at the bottom of the page, possibly a footer or additional notes.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38132

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RAE H. ABRAMSON | | | | 2. Date of Death Month Day Year 11.24.99 | | 3. Time of Death 11:05 AM | |
| | 4a. Facility Name (If not Institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 579.01.6381 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 09.03.1913 | 9. Birthplace (State or Foreign Country) WASHINGTON, DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 6111 MONTROSE ROAD | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | | 16b. Kind of Business/Industry US GOVERNMENT | |
| 17. Father's Name (First, Middle, Last) MAX HOCHMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) MINNIE KATZ | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MICHAEL ABRAMSON/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 BOSTWICK LANE, GAITHERSBURG, MARYLAND 20878 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ADAS ISRAEL CONG. CEMETERY | | Date 11.26.99 | | 20c. Location - City or Town, State WASHINGTON, DC | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HEPATIC COMA Due to (or as a consequence of): b. HEPATIC CIRRHOSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 2 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Gregory A. Compton MD | | | | 29c. License number D24942 | | 29d. Date signed (Month, Day, Year) NOV 24, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 22a) (Type, Print) GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 26 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

To Be Completed by Funeral Director

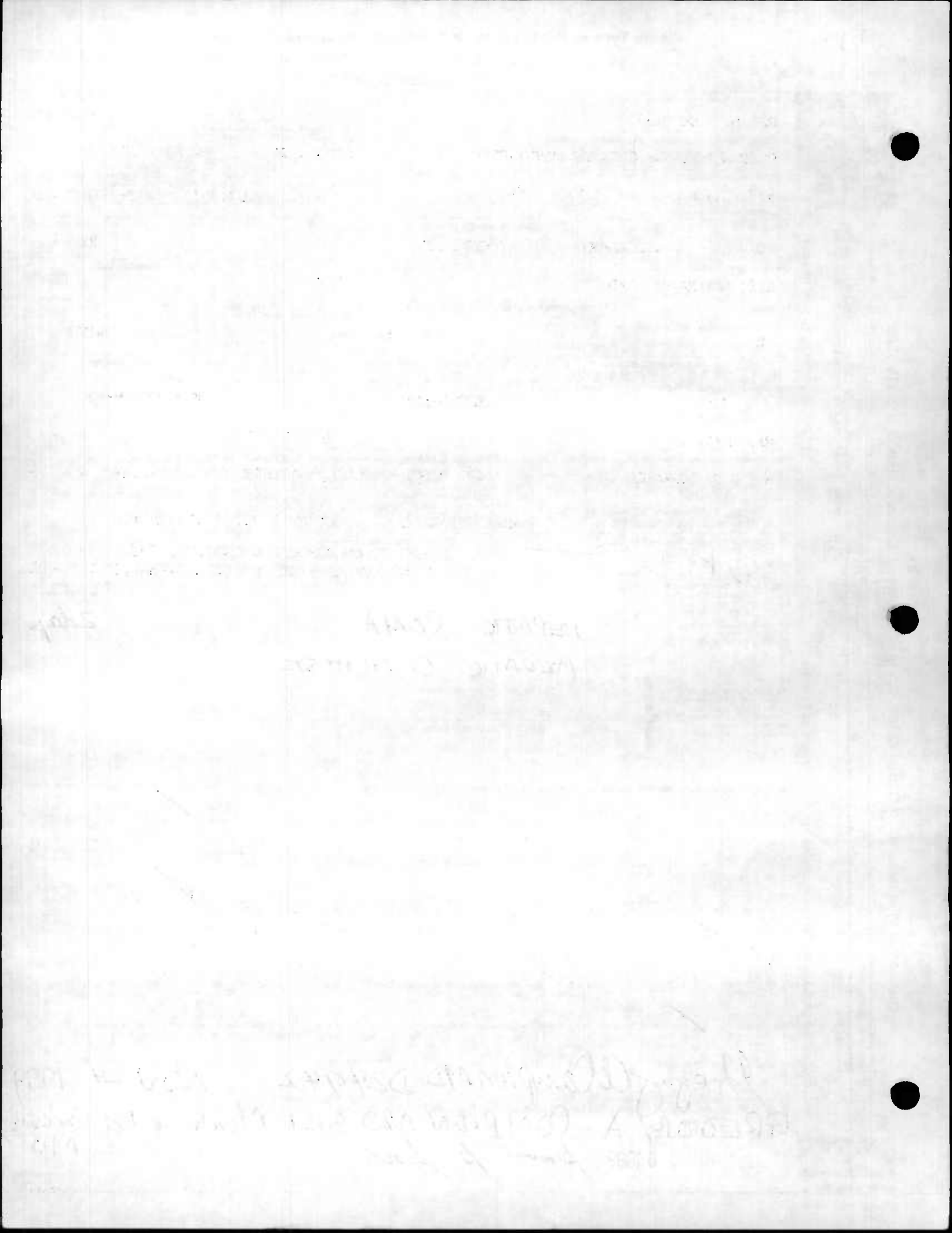
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38133

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Adams

2. Date of Death

Month Day Year
NOVEMBER 19, 1999

3. Time of Death

11:00AM

4a. Facility Name (If not institution, give street and number)

11240 CHERRY HILL ROAD

4b. City, Town, or Location of Death

BELTSVILLE

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

131-24-5065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
AUG. 31, 1928

9. Birthplace (State or Foreign Country)

NEW YORK, NY

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

BELTSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11240 CHERRY HILL ROAD

10f. Zip Code

20705

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CLERICAL

16b. Kind of Business/Industry

DISTRICT OF COLUMBIA
GOVERNMENT

17. Father's Name (First, Middle, Last)

FOSTER CONYERS

18. Mother's Name (First, Middle, Maiden Surname)

MARY SNYDER

19a. Informant's Name/Relationship (Type, Print)

MARGUERITE WOODS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8943 218TH PLACE QUEENS VILLAGE, NY 11427

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

11-22-99

20c. Location - City or Town, State

SILVER SPRING, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI 11800 NEW HAMPSHIRE
AVENUE SILVER SPRING, MARYLAND 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Less than 24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Herpes Zoster with Severe
Post-Herpetic Neuralgia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas M. Annulis, M.D.; 11120 New Hampshire Ave.; Suite 305; Bethesda, MD 20814

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

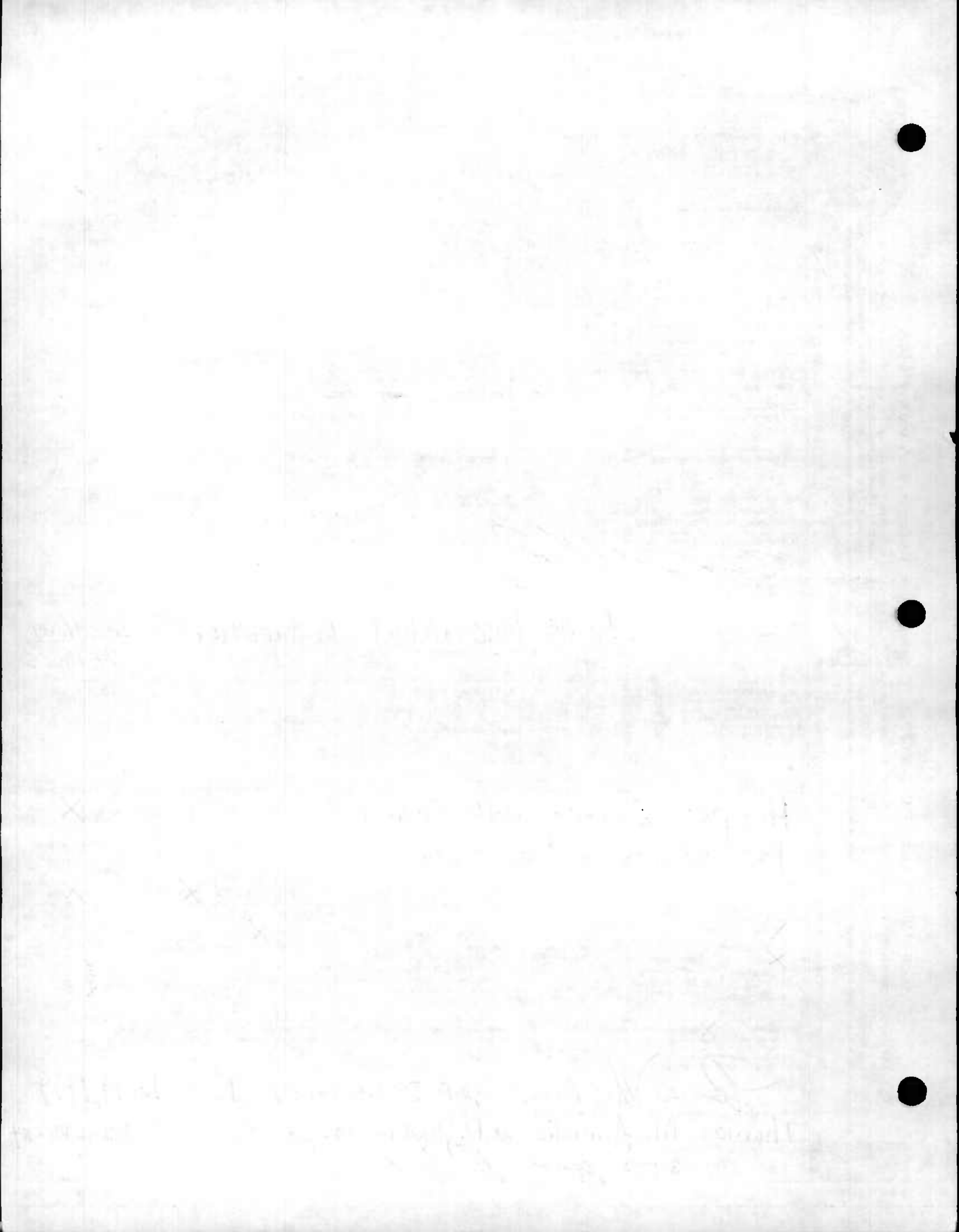
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38134

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) JAMES CHARLES ANDERSON | | | | 2. Date of Death Month 11 Day 18 Year 99 | | 3. Time of Death 1700 | |
| 4a. Facility Name (If not institution, give street and number) Atlantic General Hospital | | | | 4b. City, Town, or Location of Death Berlin | | 4c. County of Death Worcester | |
| 5. Social Security Number 203-24-1257 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 9/18/33 | |
| 9. Birthplace (State or Foreign Country) PA | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Ocean City | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 245 S. Ocean Dr. | | | | 10f. Zip Code 21842 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed | | 16b. Kind of Business/Industry Bar/Restaurant | |
| 17. Father's Name (First, Middle, Last) James Anderson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kathryn (Unknown) | | | |
| 19a. Informant's Name/Relationship (Type, Print) Susan Knoll/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Brant Court Middletown, DE 19709 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Union Hill Cemetery | | Data 11/23/99 | | 20c. Location - City or Town, State Kennett Square, PA | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FEW YEARS | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> C. Holzworth, M.D. | | | | 29c. License number D06241 | | 29d. Date signed (Month, Day, Year) 11-19-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOLZWORTH, M.D., 205 SNOW ST. SNOW HILL, MD. 21863 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38135

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BILLIE BYRD BELL | | 2. Date of Death Month Day Year NOV. 16, 1999 | | 3. Time of Death 8:00 pm |
| | 4a. Facility Name (If not institution, give street and number) WILSON HEALTH CARE CENTER | | 4b. City, Town, or Location of Death GAITHERSBURG | | 4c. County of Death MONTGOMERY |
| Funeral Director | 5. Social Security Number 579-56-8315 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan 10 1921 | | 9. Birthplace (State or Foreign Country) Washington, DC | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location GAITHERSBURG | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 301 Russell Avenue | | | |
| 10f. Zip Code 20877 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegiate (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House wife | | 16b. Kind of Business/Industry Homeowner | | | |
| 17. Father's Name (First, Middle, Last) William H. West | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Fields | | |
| 19a. Informant's Name/Relationship (Type, Print) WILLIAM T. BELL, JR. - SON | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bergmolesvagen 29 S-13567 Tyresko, Sweden | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery | | 20c. Location - City or Town, State 12/1/99 Arlington, VA | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC. 5130 WISC. AVE. NW. WASH. DC. 20016 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Hypertension, Hypothyroidism, Peripheral Vascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death 2 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Hypothyroidism, Peripheral Vascular Disease | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier P. Callahan MD | | 29c. License number 041794 | | 29d. Date signed (Month, Day, Year) November 17, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Callahan-Lyon, MD 911 Russell Avenue Gaithersburg, MD 20879 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

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1991 Fl. collection

1991 Fl. collection

1991 Fl. collection

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JoAnn Blood

2. Date of Death
Month Day Year
Nov 17 993. Time of Death
07:35AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore, Maryland

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

431-74-5840

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

8. Date of Birth

January 18, 1942

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State
Maryland10b. County
Baltimore10c. City, Town or Location
Catonsville10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

701 Edmondson Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Finance Company

17. Father's Name (First, Middle, Last)

Homer Howard Harris

18. Mother's Name (First, Middle, Maiden Surname)

Alice Jean Ghormley

19a. Informant's Name/Relationship (Type, Print)

Deanna Blood/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 Martin Lane Englewood, CO 80110

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

11/19/99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carolanne

22. Name and Address of Facility

CAFA Stephen D. Lohmann P.A.

8717 Green Pastures Drive Baltimore, Maryland 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Multiple Sclerosis

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MEDICAL RESIDENT

29c. License number

P13605

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVARISTUS NUNLLIA 900 CATON AVENUE, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

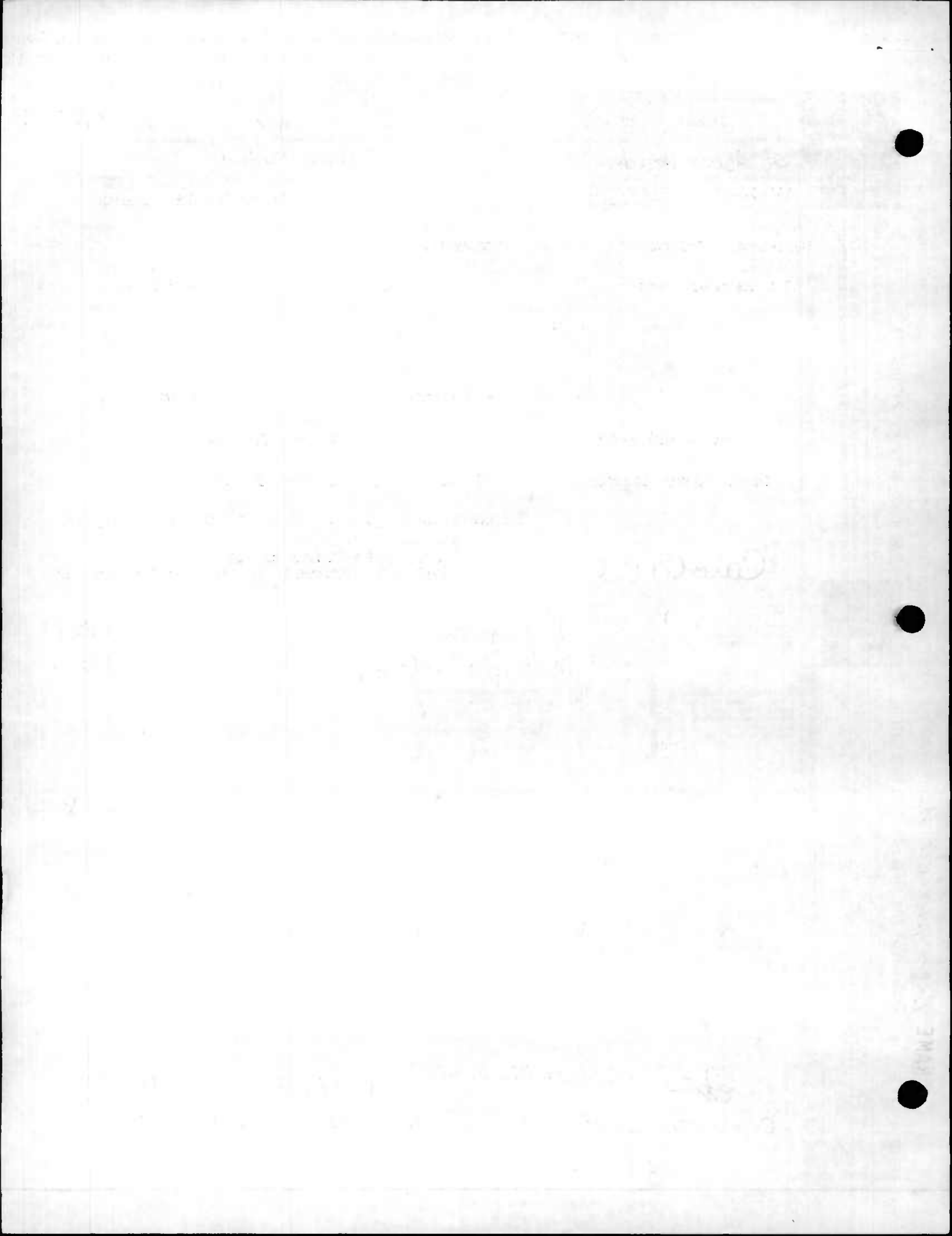
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NAME Blood, JoAnn A

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

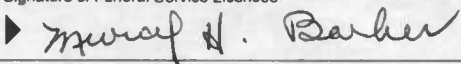
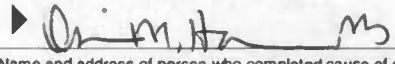
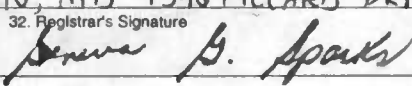
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38137

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|---|--------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) LILY EMERSON BROOKE | | | | 2. Date of Death Month NOVEMBER Day 21 , Year 1999 | | 3. Time of Death 3:15 PM | |
| 4a. Facility Name (If not institution, give street and number) MEADOWS 1641 (BROOKE GROVE FOUNDATION) | | | | 4b. City, Town, or Location of Death SANDY SPRING | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 213 48 1324 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 99 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Days | 8. Date of Birth (Month, Day, Year) SEPT. 6, 1900 | 9. Birthplace (State or Foreign Country) GEORGIA |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location SANDY SPRING | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1641 HICKORY KNOLL ROAD | | | | 10f. Zip Code 20860 | | 10g. Citizen of What Country? UNITED STATES | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) ANDREW WALDO EMERSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) VIOLET LEE JORDAN | | | |
| 19a. Informant's Name/Relationship (Type, Print) GRAND-GRACE BROOKE HUFFMAN, DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 HICKORY KNOLL ROAD, SANDY SPRING, MD. 20860 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY | | Date 11/22/99 | | 20c. Location - City or Town, State ALEXANDRIA, VA. | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME PO BOX 5038, LAYTONSVILLE, MD. 20882 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death One week |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D23124 | | 29d. Date signed (Month, Day, Year) NOVEMBER 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS M. HANNON, MD 1396 PICCARD DRIVE; ROCKVILLE MARYLAND 20855 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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10 (15)

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38138

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Marian Ina Burnsky** 2. Date of Death Month **November** Day **20** Year **1999** 3. Time of Death **7:00 pm**

Funeral
Director

4a. Facility Name (If not Institution, give street and number) **Holy Cross Hospital** 4b. City, Town, or Location of Death **Silver Spring** 4c. County of Death **Montgomery**

5. Social Security Number **325-12-7818** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **78** Yrs. 8. Date of Birth (Month, Day, Year) **March 28, 1921** 9. Birthplace (State or Foreign Country) **Illinois**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Montgomery** 10c. City, Town or Location **Rockville** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **13201 Vandalia Drive** 10f. Zip Code **20853** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12** Collega (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **George H. Smith** 18. Mother's Name (First, Middle, Maiden Surname) **Ina Shipway**

19a. Informant's Name/Relationship (Type, Print) **Paul Burnsky (husband)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **13201 Vandalia Drive Rockville, Maryland 20853**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Metropolitan Crematory** 20c. Location - City or Town, State **11/22/99 Alexandria, Virginia**

21. Signature of Funeral Service Licensee **Francis J. Collins Funeral Home, Inc.** 22. Name and Address of Facility **500 University Blvd., W., Silver Spring, MD 20901**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **a. Cardiomyopathy** Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Frederic T. Schwartz M.D.** 29c. License number **D 23456** 29d. Date signed (Month, Day, Year) **November 22, 1999**

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) **Frederic T. Schwartz, M.D. 5454 Wisconsin Avenue Chevy Chase, Maryland 20815**

31. Date filed (Month, Day, Year) **NOV 23 1999** 32. Registrar's Signature **B. Sparks**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38139
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Forman Blanchard

2. Date of Death

November 21, 1999

3. Time of Death

1:10 P.M.

4a. Facility Name (If not institution, give street and number)

12444 Fingerboard Road

4b. City, Town, or Location of Death

Monrovia

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

213-56-1722

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 12, 1950

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Monrovia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12444 Fingerboard Road

10f. Zip Code

21770

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

1969-

1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Title Supervisor

16b. Kind of Business/Industry

Real Estate Title

Insurance

17. Father's Name (First, Middle, Last)

Elmer Francis Blanchard

18. Mother's Name (First, Middle, Maiden Surname)

Glenda Forman

19a. Informant's Name/Relationship (Type, Print)

Pamela A. Blanchard/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12444 Fingerboard Road, Monrovia, Maryland 21770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

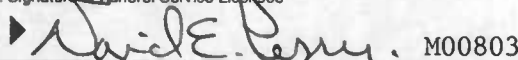
Nov 24

1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee



M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc. 300 West Montgomery Avenue

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Pancreatic Carcinoma

Due to (or as a consequence of):

6 Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

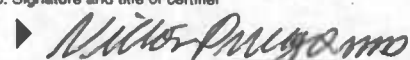
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D23308

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Victor M. Priego, M.D. 6410 Rockledge Drive, #625, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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15 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38140

Amend #8, 11/30/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|---|--|--|---|--|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WALTER BELL | | | | 2. Date of Death November 21, 1999 | | | | 3. Time of Death 2:11 A. M. | | | | |
| | 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL | | | | 4b. City, Town, or Location of Death BETHESDA | | | | 4c. County of Death MONTGOMERY | | | | |
| Funeral Director | 5. Social Security Number 579-05-3061 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 28, 1915 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | | | |
| | Usual Residence of Decedent | | | | 10a. State FLORIDA | | | | 10b. County PALM BEACH | | 10c. City, Town or Location BOCA RATON | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 500 SOUTH OCEAN BLVD., # 2205 | | | | 10f. Zip Code 33432 | | 10g. Citizen of What Country? U. S. A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 YEAR | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE | | | | 16b. Kind of Business/Industry RETAIL | | | | | |
| 17. Father's Name (First, Middle, Last) SAMUEL BELL | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA ROTKIN | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) FREDERIC BELL - SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10605 TROTTERS TRAIL, POTOMAC, MARYLAND 20854 | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDEN | | | | 20c. Location - City or Town, State FALLS CHURCH, VIRGINIA | | | | | |
| 21. Signature of Funeral Service Licensee Donald C. Stottmeyer | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SMOKE INHALATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) UNKNOWN | | 28b. Time of Injury UNKNOWN | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred VICTIM OF HOUSE FIRE | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9012 BELMONT ROAD 20850 | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Dawn Coleman | | | | 29c. License number O. C. M. E | | 29d. Date signed (Month, Day, Year) NOVEMBER 21, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, M. D. 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 26 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-5000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38141

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOIS JEAN BELL

2. Date of Death

NOV. 17, 1999

3. Time of Death

2:47 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

349-40-2562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 18, 1946

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11830 Winter Long Way

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Precious Bell

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Sample

19a. Informant's Name/Relationship (Type, Print)

Rose Bell Hayward (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3808 Blaisdell Ave., So, #106, Minneapolis, MN 55409

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenwood Cemetery 11/23/99 Rockford, IL

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Approximate interval Between Onset and Death

2 hrs

b. Severe Coagulopathy, Hyperkalemia & Acidosis

Due to (or as a consequence of):

4 hrs

c. Cellulitis & possible Sepsis

Due to (or as a consequence of):

2 days

d. Severe Cor. Pulmonale

4 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe pulmonary hypertension

Recurrent Thromboembolism to lung

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Shawn MD

29c. License number

53601

29d. Date signed (Month, Day, Year)

NOVEMBER, 17 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOITSIN IJAZ, MD 11119 ROCKVILLE PIKE, SUITE 100

MD 20852

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38142

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM ARTHUR BEALL

2. Date of Death

Month Day Year
NOVEMBER 18, 1999

3. Time of Death

8:00PM

4a. Facility Name (If not institution, give street and number)

MANOR CARE OF WHEATON

4b. City, Town, or Location of Death

WHEATON

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-09-5417 A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 30, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11806 JUDSON ROAD

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PRINTER

16b. Kind of Business/Industry

NATIONAL COAL
ASSOCIATION

17. Father's Name (First, Middle, Last)

JAMES ARTHUR BEALL

18. Mother's Name (First, Middle, Maiden Surname)

EFFIE BEST

19a. Informant's Name/Relationship (Type, Print)

VIOLET VERA BEALL (SPOUSE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11806 JUDSON ROAD SILVER SPRING, MD 20902

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FT. LINCOLN CREMATORY

Date

11-22-99

20c. Location - City or Town, State

BRENTWOOD, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI 11800 NEW HAMPSHIRE
AVENUE SILVER SPRING, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d. HYPERTENSION

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D32817

29d. Date signed (Month, Day, Year)

NOVEMBER 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. WAJEED KHAN M.D. 12016 GEORGIA AVENUE WHEATON, MD 20902

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
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Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38143

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Juanita R. Barzelatto

2. Date of Death
Month Day Year
November 21, 19993. Time of Death
12:30PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

215-74-0443

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 16, 1926

9. Birthplace (State or Foreign Country)

Chile

Usual Residence of Decedent

10a. State

Florida

10b. County

Brevard

10c. City, Town or Location

Merritt Island

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2586 Sykes Creek Drive

10f. Zip Code

32953

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Chilean

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Carlos Ramirez

18. Mother's Name (First, Middle, Maiden Surname)

Isaura Carrasco

19a. Informant's Name/Relationship (Type, Print)

Jose Barzelatto/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2586 Sykes Creek Drive, Merritt Island, Florida 32953

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Nov 24

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Daniel E. Perry M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

22 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Rosenberg MD

29c. License number

D04766

29d. Date signed (Month, Day, Year)

11-22-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEL ROSENBLUM, MD
10400 CONNECTICUT AVE STE 606 KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-1234.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38144

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ERNA BERTA BAER | | | | 2. Date of Death Month Day Year 11.21.1999 | | 3. Time of Death 10:10 PM | |
| 4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GERATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 075.18.8232 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) 08.03.1910 | |
| 9. Birthplace (State or Foreign Country) GERMANY | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location GAITHERSBURG | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 2 BRIGHTON TERRACE | | | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? UNITED STATES | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) JULIUS BAUER | | | | 18. Mother's Name (First, Middle, Maiden Surname) SELMA SPIER | | | |
| 19a. Informant's Name/Relationship (Type, Print) ANNE LOEWENTRITT/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BRIGHTON TERRACE, GAITHERSBURG, MARYLAND 20877 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR PARK CEMETERY | | 20c. Date 11.23.99 | | 20d. Location - City or Town, State WESTWOOD, NEW JERSEY | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Pneumonia</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <u>Mary J. Wilks, MD</u> | | | | 29c. License number D 0055258 | | 29d. Date signed (Month, Day, Year) November 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY WILKS, MD Hebrew Home of Washington 6121 Montrose Road Rockville, Maryland 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature <u>Beverly G. Sparks</u> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38145

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

RUTH

MILLIDINE

BARCLAY

2. Date of Death
Month Day Year
November 6, 19993. Time of Death
04:50

4a. Facility Name (If not institution, give street and number)

KENT & QUEEN ANNES HOSPITAL

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT

5. Social Security Number

265-38-3321

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
December 3, 1929

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Ingleside

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2016 Goldsboro Road

10f. Zip Code

21644

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

George H. Foley

18. Mother's Name (First, Middle, Maiden Surname)

Janie Smith

19a. Informant's Name/Relationship (Type, Print)

Charles Wallace/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

219 Burchard Saw Mill Road, Chestertown, MD 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Church Hill Cemetery

Date

11/9/99

20c. Location - City or Town, State

Church Hill, Maryland

21. Signature of Funeral Service Licensee

Dary B. Fellows

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Vaginal Carcinoma
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ACUTE SUDDEN FATALITY
Due to (or as a consequence of):

2 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)29b. Signature and title of certifier
John C. Seymour

29c. License number

A-13824

29d. Date signed (Month, Day, Year)

11-6-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John C. Seymour, 122 Speer Road, Suite 5, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

NOV 08 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

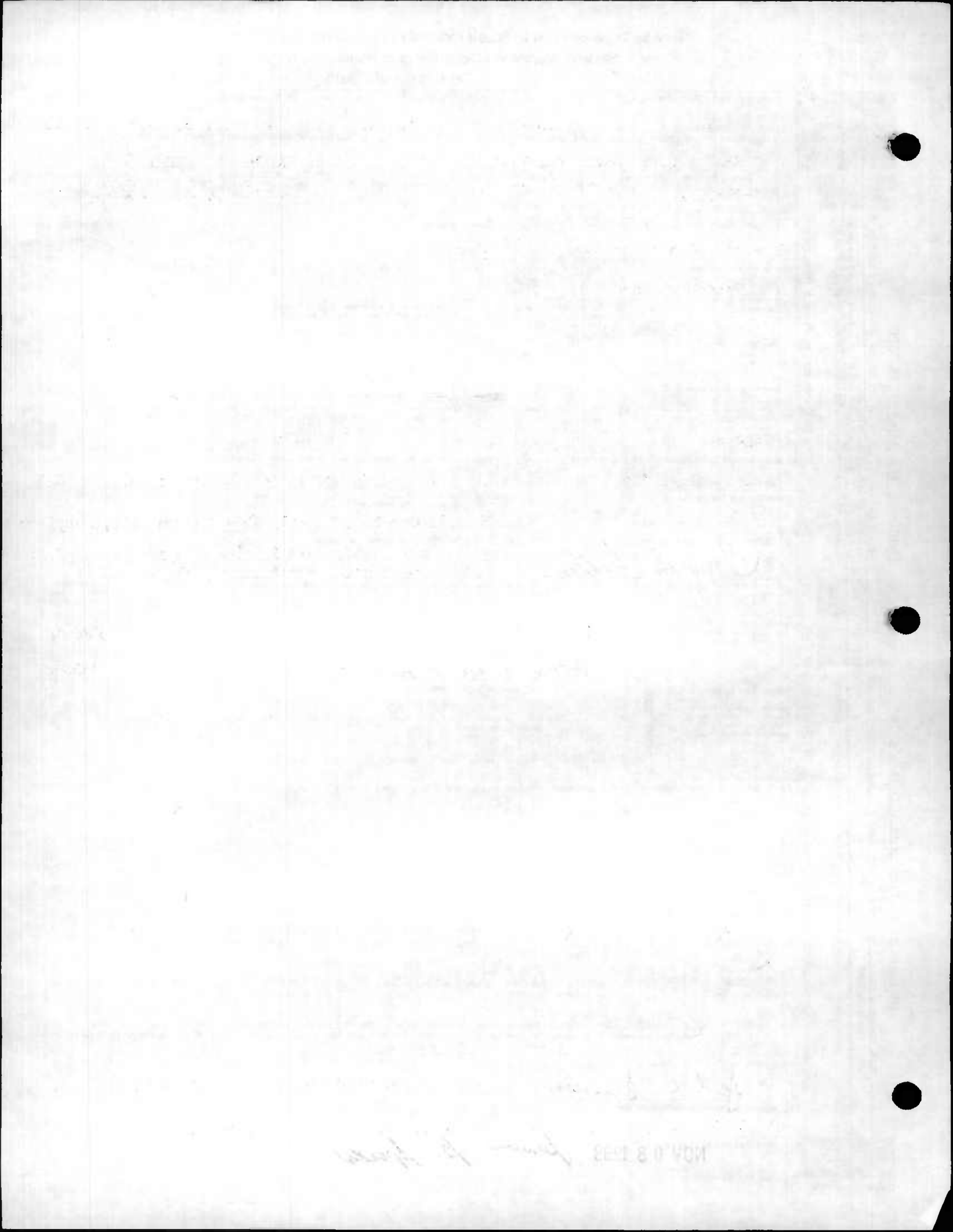
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38146

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|--|--|---|---|--|--|--|---|----------------|----|--|----|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DAVID S. BARE | | | | 2. Date of Death Month Day Year 11-17-99 | | 3. Time of Death 1555 | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death WESTMINSTER | | 4c. County of Death CARROLL | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 216-03-9172 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 4/7/1912 | 9. Birthplace (State or Foreign Country) MARYLAND | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD. | | 10b. County CARROLL | | 10c. City, Town or Location TANEYTOWN | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | |
| | 10e. Street and Number 464 E. BALTIMORE ST. | | | | 10f. Zip Code 21787 | | 10g. Citizen of What Country? USA. | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | | | 16b. Kind of Business/Industry TRANSPORTATION | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) SAMUEL DAVID BARE | | | | 18. Mother's Name (First, Middle, Maiden Surname) HATTIE YOUNG | | | | | | | | | | | | | | | |
| Physician /Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) LOUISE BARE -WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 464 E. BALTIMORE ST., TANEYTOWN, MD. 21787 | | | | | | | | | | | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOW BRANCH CEM. | | 20c. Date 11/20/99 | | 20d. Location - City or Town, State WESTMINSTER, MD. | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | | | | | | | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Ventricular fibrillation Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death Instant</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. Acute myocardial infarction Due to (or as a consequence of):</td> <td>3 hours</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Ventricular fibrillation Due to (or as a consequence of): | Approximate Interval Between Onset and Death Instant | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Acute myocardial infarction Due to (or as a consequence of): | 3 hours | c. | | d. | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. Ventricular fibrillation Due to (or as a consequence of): | Approximate Interval Between Onset and Death Instant | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Acute myocardial infarction Due to (or as a consequence of): | 3 hours | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of prostate Drobleter Kellitus | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D18 800 | | 29d. Date signed (Month, Day, Year) 11/17/99 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTEDU N. KANNA MD 700-A POOR RD WESTMINSTER MD 21157 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1954. 11. 11

Handwritten signature

Seite 1 von 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38147

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Orlando James Bivens** 2. Date of Death (Month, Day, Year) **NOVEMBER 17, 1999** 3. Time of Death **1831**

4a. Facility Name (If not institution, give street and number) **PENINSULA REGIONAL MEDICAL CENTER** 4b. City, Town, or Location of Death **SALISBURY** 4c. County of Death **WICOMICO**

Funeral
Director

5. Social Security Number **213-42-0833** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **55** Yrs. 8. Date of Birth (Month, Day, Year) **MAR. 12, 1944** 9. Birthplace (State or Foreign Country) **MARYLAND**

Usual Residence of Decedent 10a. State **md** 10b. County **Wicomico** 10c. City, Town or Location **Salisbury** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **4019 Dish Room Rd** 10f. Zip Code **21822** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Navar Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. **AFR. AMERICAN**

15. Decedent's Education (Specify only highest grade completed) **12** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Self-Employed** 16b. Kind of Business/Industry **Mechanist**

17. Father's Name (First, Middle, Last) **Glen More James Bivens** 18. Mother's Name (First, Middle, Maiden Surname) **Mary Virtie White Bivens**

19a. Informant's Name/Relationship (Type, Print) **Lillie White Sister** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Box 791 Salisbury Md. 21824**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **St. Mary's Baptist Ch.** 20c. Location - City or Town, State **Salisbury, Md**

21. Signature of Funeral Service Licensee **John D. Prince** 22. Name and Address of Facility **BENNIE SMITH PR. ANN B. md 917 W. Isabelle St Salisbury**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Laryngeal Carcinoma** Approximate Interval Between Onset and Death **months**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier **John D. Prince** 29c. License number **D29105** 29d. Date signed (Month, Day, Year) **11/19/99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CHRISTOPHER HUDDLESTON, MD 106 Milford St. Salisbury, MD**

31. Date filed (Month, Day, Year) **NOV 29 1999** 32. Registrar's Signature **John B. Sparks**

To Be Completed by Funeral Director

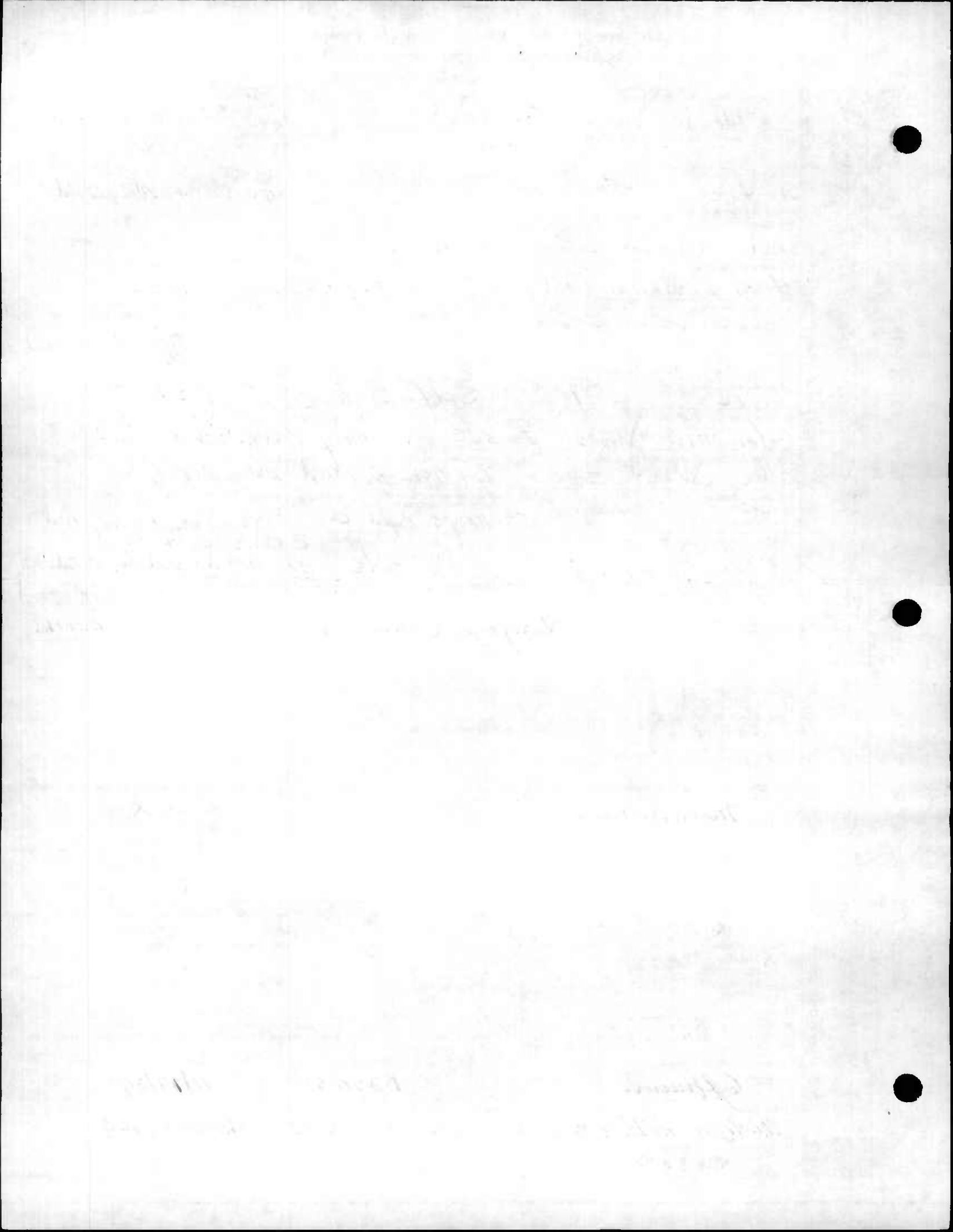
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38148

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Taylor Bowmann

2. Date of Death

11 20 1999

3. Time of Death

8:35pm

4a. Facility Name (If not institution, give street and number)

1606 Boston Road

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

213-22-4786

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/19/1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1606 Boston Road

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Lemuel Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Mason

19a. Informant's Name/Relationship (Type, Print)

Charles Bowmann (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1606 Boston Rd., Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pitts Creek Presbyterian Cemetery

Date

11/24/99

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Service Licensee

Michael A. Dean 11/12/99

22. Name and Address of Facility

Holloway Melson Funeral Home
103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA Colon
Due to (or as a consequence of):
b. metastasis lung
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate interval Between Onset and Death

Yrs.
months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Madhav D. Barhan

29c. License number

12764

29d. Date signed (Month, Day, Year)

11/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 Madhav D. Barhan 4384 Crisfield Hwy., Crisfield, MD 21817

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

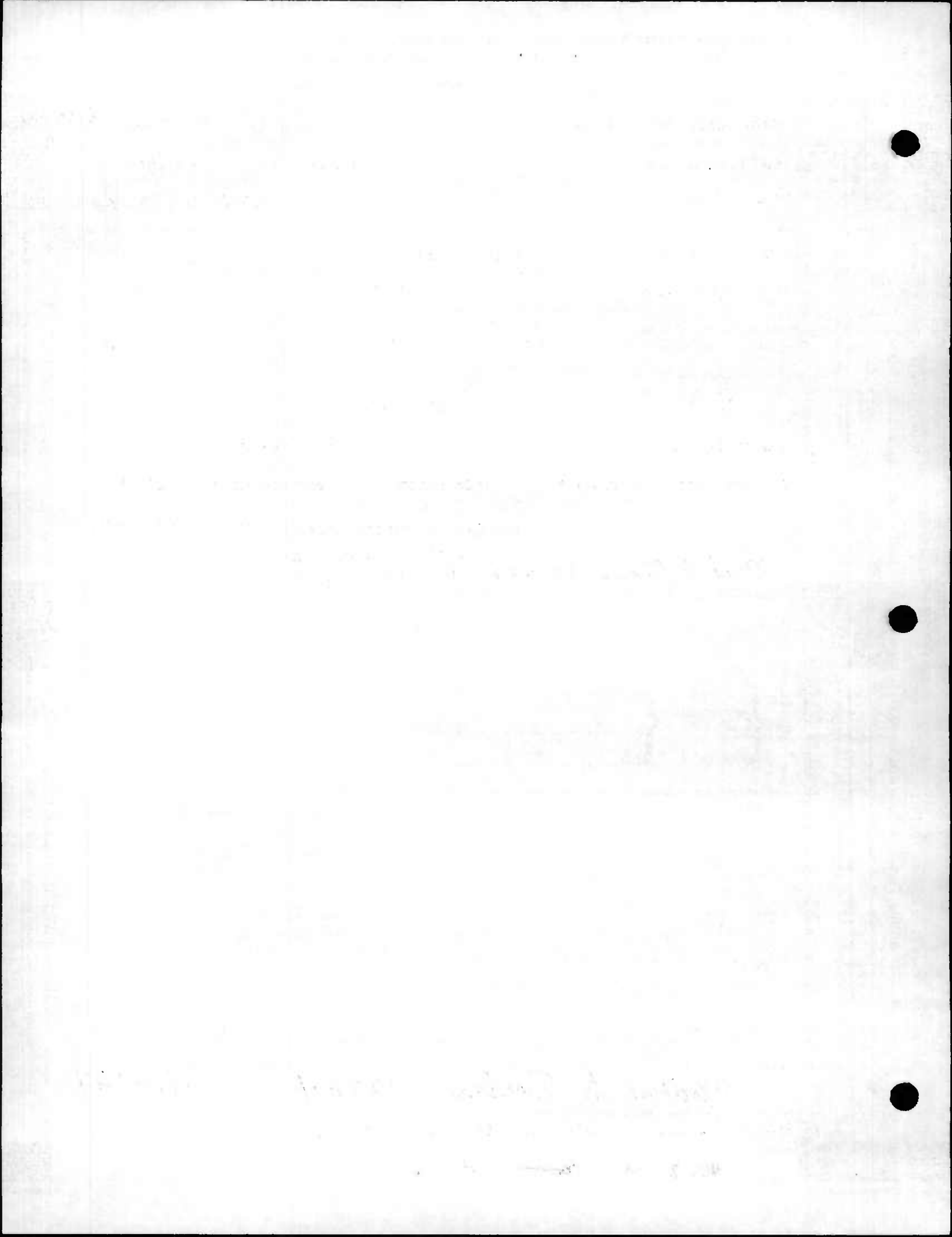
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38149

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles William Bratten

2. Date of Death

Month Day Year

11 10 99

3. Time of Death

7:00 P.M.

4a. Facility Name (If not institution, give street and number)

Snow Hill Nursing & Rehab

4b. City, Town, or Location of Death

Snow Hill

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

214-28-8321

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-30-23

9. Birthplace (State or Foreign Country)

SNOW HILL MD

Usual Residence of Decedent

10e. State

MD

10b. County

Worcester

10c. City, Town or Location

SNOW HILL

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 FEDERAL ST

10f. Zip Code

21863

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

GRADE-4

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABOR

16b. Kind of Business/Industry

IND STORE

17. Father's Name (First, Middle, Last)

LAWRENCE BRATTEN

18. Mother's Name (First, Middle, Maiden Summa)

EINORA LAWS

19a. Informant's Name/Relationship (Type, Print)

EDWARD BRATTEN (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6812 FOREST LAVE, RD SNOW HILL, MD 21863

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Westing

Date

11/13/99

20c. Location - City or Town, State

SNOW HILL, MD

21. Signature of Funeral Service Licensee

Bennie Smith F/H Salisbury MD 21801

22. Name and Address of Facility

917 W. ISABELLA ST

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CHRONIC RENAL FAILURE

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL HEMORRHAGE
FROM COLON CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bennie Smith M.D.

29c. License number

050759

29d. Date signed (Month, Day, Year)

11/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

108 PINEBLUFF RD SALISBURY MD 21801

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38150

Amend #18, 19a, 11/30/99, JW, Montg. Co. Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) TALMADGE A. COX | | | | 2. Date of Death Month Day Year Nov 18, 1999 | | | | 3. Time of Death 5:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death Laurel | | | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 244-24-2095 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 10, 1922 | | 9. Birthplace (State or Foreign Country) N. CAROLINA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location BURTONSVILLE | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 14601 OLD COLUMBIA PIKE | | | | 10f. Zip Code 20866 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY OFFICER | | | 16b. Kind of Business/Industry D.C. GOV'T | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) A. M. D. COX | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMMALINE RUTHERFORD | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) VERA C. KLEUVER / SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Date 11/23/99 | | 20c. Location - City or Town, State RIVERDALE, MD. | | | |
| | 21. Signature of Funeral Service Licensee W.W. Chambers M00091 | | 22. Name and Address of Facility SILVER SPRING, MD. CHAMBERS FUNERAL HOMES, P.A. 20906 | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. CARCINOMA OF LUNG Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 1 WK 1 YEAR | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Harjit S. Basaj MD | | 29c. License number D43378 | | 29d. Date signed (Month, Day, Year) Nov, 20, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT S. BASAJ, 3455, Wilkerson Ave., Baltimore MD - 21229 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature Geneva B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38151

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles C. Coupard

2. Date of Death
Month Day Year
November 20, 19993. Time of Death
6:10 pmFuneral
Director

4a. Facility Name (If not institution, give street and number)

1954 Seminary Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

219-05-9772

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 13, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1954 Seminary Road

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Montgomery County
Transportation Dept.

17. Father's Name (First, Middle, Last)

Charles Coupard

18. Mother's Name (First, Middle, Maiden Surname)

Annie Dowden

19a. Informant's Name/Relationship (Type, Print)

Aida A. Coupard/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1954 Seminary Road, Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Cemetery

Date

Nov 23
1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Epi S. Scerbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W, Silver Spring, MD 20901

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

b. Coronary artery Disease

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d. congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert F. K... MD

29c. License number

D43414

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert F. K... 10301 Lockwood Drive Silver Spring MD 20901

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38152

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH L. COOPER

2. Date of Death

NOV 17 1999

3. Time of Death

8:20pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST NURSING & REHAB CENTER

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

265.96.2577

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

12.03.1901

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4613 GREAT OAK ROAD

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JACOB VanBuren COCHRAN

18. Mother's Name (First, Middle, Maiden Surname)

ALMA ELIZABETH BRANNON

19a. Informant's Name/Relationship (Type, Print)

JAMES C. COOPER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4613 GREAT OAK ROAD, ROCKVILLE, MARYLAND 20853

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JACKSONVILLE MEMORIAL GDN 11.20.99 ORANGE PARK, FLORIDA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Deep vein thrombosis

YRS.

Due to (or as a consequence of):

b.

Peptic ulcer disease

YRS.

Due to (or as a consequence of):

c.

Diverticulosis

YRS.

Due to (or as a consequence of):

d.

osteoporosis

YRS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

D35792

29d. Date signed (Month, Day, Year)

NOVEMBER, 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWAROFF, G. RAO; 50, W. EDMONSTON DR; ROCKVILLE, MD.

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38153

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Joyce Cooke

2. Date of Death

November 19, 1999

3. Time of Death

12:47 A.M.

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

214-48-2242

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 28, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2311 Newton Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

William E. Cooke, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Widic

19a. Informant's Name/Relationship (Type, Print)

Patrick H. Fauber, Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2311 Newton Drive, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

Nov. 23, 1999

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

W. E. Cooke, Jr. M00672

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC PAPILLARY SEROUS

Due to (or as a consequence of)

CARCINOMA of PERITONEUM

Approximate Interval Between Onset and Death

1 YEAR AND 3 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carolyn B Hendricks MD

29c. License number

D37236

29d. Date signed (Month, Day, Year)

November 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn B Hendricks MD

6410 ROCKLEDGE DRIVE

BETHESDA MD 20817

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Benjamin G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38154

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philander Priestley Claxton, Jr.

2. Date of Death

November 20, 1999

3. Time of Death

8:46 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9707 Old Georgetown Road #1501

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

215-38-2711

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

December 11, 1914

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9707 Old Georgetown Road #1501

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1943-
If Yes, Give Year or Dates: 1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Diplomat

16b. Kind of Business/Industry

Department of State

17. Father's Name (First, Middle, Last)

Philander P. Claxton, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hannah Johnson

19a. Informant's Name/Relationship (Type, Print)

Mary Ann E. Claxton/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20817

9707 Old Gerogetown Road #1501, Bethesda, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

December 13, 1999

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Michael E. Higgins M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Generalized Carcinomatosis

2 months

Due to (or as a consequence of):

b. Hormone Refractory Prostate Cancer

20 Months

Due to (or as a consequence of):

c. Prostate Cancer

12 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chu Maung

29c. License number

D45274

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chu Maung, M.D., 10812 Connecticut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Sandra B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38155

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDEGARDE CICALA

2. Date of Death

Month Day Year
NOVEMBER 17, 1999

3. Time of Death

9:11 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

216-40-7417

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
FEB. 2, 1943

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BURTONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15605 OURSLER ROAD

10f. Zip Code

20866

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ELIJAH SHORTT

18. Mother's Name (First, Middle, Maiden Surname)

PERNEDA LITTLE

19a. Informant's Name/Relationship (Type, Print)

DOMENICO CICALA/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15605 OURSLER RD. BURTONSVILLE, MARYLAND 20866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY 11/22/99 SILVER SPRING, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HYPOXEMIA

Approximate Interval Between Onset and Death

HOURS

Due to (or as a consequence of):

PULMONARY INSUFFICIENCY

DAYS

Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE PULMONARY

YEARS

Due to (or as a consequence of):

DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

CORONARY ARTERY DISEASE

MITRAL VALVE DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 18 551

29d. Date signed (Month, Day, Year)

11/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR NEIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD.

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38156

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gus M Cerimele | | | | 2. Date of Death Month November Day 19 Year 1999 | | 3. Time of Death 5:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick | |
| Funeral Director | 5. Social Security Number 577-05-5901 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 12, 1908 | | 9. Birthplace (State or Foreign Country) Wash., D.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Brunswick | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10a. Street and Number 505 West Potomac St. | | | | 10f. Zip Code 21716 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brick mason | | 16b. Kind of Business/Industry Self-employed | | |
| 17. Father's Name (First, Middle, Last) Costanzio Cerimele | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Messina | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Daria Bennett / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 West Potomac Street Brunswick, Maryland 21716 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery | | Date Nov. 23 1999 | | 20c. Location - City or Town, State Washington, D.C. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW Washington, DC 20007 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ruptured abdominal aortic aneurysm Due to (or as a consequence of): b. hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D0054705 | | 29d. Date signed (Month, Day, Year) 11/19/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine S. Maul Buti 300 West Ninth Street Frederick MD 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38157

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Beth Carlton

2. Date of Death

November 21, 1999

3. Time of Death

10:00 am

4a. Facility Name (If not institution, give street and number)

Manor Care- Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

021-40-9418

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 30, 1951

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7420 Westlake Terrace

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mail Clerk

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

David L. Joffes

18. Mother's Name (First, Middle, Maiden Surname)

Rosalyn E. Cutler

19a. Informant's Name/Relationship (Type, Print)

Steven Carlton/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7420 Westlake Terrace, Bethesda, MD 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Nov 27
1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Eric S. Scerbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Days

mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

S. A. RAD

29c. License number

D35792

29d. Date signed (Month, Day, Year)

NOVEMBER, 22, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. A. RAD; 50, W. EDMONSTON DR, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38158

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOCELYN A. DODD

2. Date of Death

Month Day Year
NOV. 17, 1999

3. Time of Death

5:50 PM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

579-76-3798

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 15, 1957

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10411 Laren Lane

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 +

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

General Contractor

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Wilbert H. DeLaine, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Anna M. Boyd

19a. Informant's Name/Relationship (Type, Print)

Frank H. Dodd - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10411 Laren Lane, Clinton, MD 20735

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cem.

Date

11/23/99

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.
600 Kenned, Street, N.W., Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Metastatic Breast

Due to (or as a consequence of):

c. Cancer to Lungs

Due to (or as a consequence of):

d. Liver & Brain

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0053219

29d. Date signed (Month, Day, Year)

11.18.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8926 Woodyard Road, #101 Clinton, MD 20735

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38159

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|---|---|--|-----------------------------------|---|--------------|-------|----------------------------------|--|-----------------------------|-------|----------------------------------|--|----|--|--|----------------------------------|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Harold Day | | | | 2. Date of Death Month Day Year November 20, 1999 | | 3. Time of Death 9:20 P.M. | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Bethesda | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 257-40-7061 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | 8. Date of Birth (Month, Day, Year) June 13, 1924 | 9. Birthplace (State or Foreign Country) Kentucky | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State Md | | 10b. County Montgomery | | 10c. City, Town or Location Takoma Park | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 904 Houston Ave., #3 | | | | 10f. Zip Code 20912 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943- | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman | | 16b. Kind of Business/Industry Self-Employed | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Harry Leigh Day | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Ada St. John | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jack R. Day (brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Waddell Circle Oak Ridge, Tenn. 37830 | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date 11/26/99 | | 20c. Location - City or Town, State Alexandria, Va. | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash.D.C. 20007 | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Pneumonia</td> <td>1 day</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Congestive Heart Failure</td> <td>1 day</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">c.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Pneumonia | 1 day | Due to (or as a consequence of): | | b. Congestive Heart Failure | 1 day | Due to (or as a consequence of): | | c. | | | Due to (or as a consequence of): | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Pneumonia | 1 day | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Congestive Heart Failure | 1 day | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D19609 | | 29d. Date signed (Month, Day, Year) November 24, 1999 | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, M.D., 10810 Darnestown Road, Suite #202 Gaithersburg, MD 20878-2675 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 26 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38160

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis B. Davis

2. Date of Death
Month Day Year
November 19, 19993. Time of Death
8:40 AM

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-40-0154

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 9, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

703 Lawnsberry Pl.

10f. Zip Code

20901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Officer

16b. Kind of Business/Industry

Central Intelligence

Agency

17. Father's Name (First, Middle, Last)

Emil Davis

18. Mother's Name (First, Middle, Maiden Sumame)

Lena Burke

19a. Informant's Name/Relationship (Type, Print)

Dr. Howard Davis/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2184 N. Bay Rd. Miami Beach, FL. 33140

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Beth Shalom Cong. Cemetery 11/21

Date

20c. Location - City or Town, State

Washington, DC.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stein Hebrew Memorial Funeral H.

232 Carroll St. NW. Washington, DC. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. bowel perforation

Due to (or as a consequence of):

b. coronary artery disease

Due to (or as a consequence of):

c. renal insufficiency

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 days

75 yrs

2 yrs

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

40611

29d. Date signed (Month, Day, Year)

11/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Schneider 10313 Georgia Ave # 307 Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2024.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38161

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OLIVIA HOLCOMB ELLERY

2. Date of Death

Month Day Year
NOV. 23, 1999

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

MANOR CARE NURSING HOME

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

091-20-6473

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 16, 1908

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10714 POTOMAC TENNIS LA.

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

ROGER

HOLCOMB

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE

deZENG

19a. Informant's Name/Relationship (Type, Print)

OLIVIA W. GUTOFF/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2028 HENDERSON AVE., WHEATON, MD. 20903

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHAMBERS CREMATORY

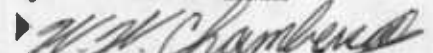
Date

11/23/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Approximate Interval Between Onset and Death

2d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

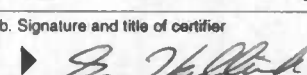
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier



29c. License number

D-28426

29d. Date signed (Month, Day, Year)

November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Galen Hallick MD 11125 Rockville Pike, Rockville, MD 20852

31. Date filed (Month, Day, Year)

NOV 26 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38162

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUDMILLA W. ERICH | | | | 2. Date of Death Month Day Year NOV. 21, 1999 | | 3. Time of Death 8:15 PM | |
| | 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death OLNEY | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 205-24-7698 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 2, 1909 | 9. Birthplace (State or Foreign Country) CROATIA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 14514 HOMECREST RD. #L5 | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER | | | 16b. Kind of Business/Industry PUBLIC SCHOOLS | |
| 17. Father's Name (First, Middle, Last) VLADIMIR FRISTACKI | | | | 18. Mother's Name (First, Middle, Maiden Surname) LJUBICA KONČEVSKI | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MIRIAM V. DOW/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 WOODLAWN RD., CHEVY CHASE, MD, 20815 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | 20c. Date 11/23/99 | | 20d. Location - City or Town, State RIVERDALE, MD. | | |
| 21. Signature of Funeral Service Licensee <i>W.H. Chambers</i> | | | | 22. Name and Address of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 24 HRS 2 WEEKS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION HYPERTENSION | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Robert Fields MD</i> ATTENDING | | 29c. License number D34740 (MD) | | 29d. Date signed (Month, Day, Year) 11/22/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT FIELDS, MD 18111 PRINCE PHILIP DR, T-12, OLNEY, MD 20832 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NO. 24. 012- (2) . 101
MAY 2, 1906
CO. 100-10-03

RECEIVED
CO. 100-10-03

RECEIVED
CO. 100-10-03
MAY 2, 1906
CO. 100-10-03

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38163

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

RUTH M. FLOWERS

2. Date of Death

November 17 1999 2:10 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

225-07-6987

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 1, 1918

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State
Maryland

10b. County

Dorchester

10c. City, Town or Location

Fishing Creek

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1205 Flowers Rd.

10f. Zip Code

21634

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Patrick McDowell

18. Mother's Name (First, Middle, Maiden Surname)

Alice Madra

19a. Informant's Name/Relationship (Type, Print)
Madeline F. Moore Benussi Daughter19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
31633 Hideaway Dr., Parsonsburg, MD 21849

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cambridge Crematory

Date

11-19

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Deep venous thrombosis of Bilateral Lower Extremities

Due to (or as a consequence of):

Months

c. Ascites

Due to (or as a consequence of):

Weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Iron Deficiency Anemia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0053198

29d. Date signed (Month, Day, Year)

November 18, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARK E. VELARDE, MD 503 BYRN ST, Suite 1, Cambridge MD 21613

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38164

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) HARRY HARGETT FRALEY JR. | | | | 2. Date of Death Month Day Year November 22 1999 | | 3. Time of Death 22:15 | |
| 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | |
| 5. Social Security Number 214-18-8878 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 14 1918 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Derwood | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 17800 Bowie Mill Road | | | | 10f. Zip Code 20855 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | 16b. Kind of Business/Industry Farming | |
| 17. Father's Name (First, Middle, Last) Harry H. Fraley Sr. | | | | 16. Mother's Name (First, Middle, Maiden Surname) Lulu Duval | | | |
| 19a. Informant's Name/Relationship (Type, Print) Eleanor W. Fraley / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17800 Bowie Mill Road, Derwood, Maryland 20855 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Laytonsville Cemetery | | Date 11/27/99 | | 20c. Location - City or Town, State Laytonsville, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 2 Days Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D42777 | | 29d. Date signed (Month, Day, Year) November 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Weinstein 1811 Prince Philip Drive Olney, MD 20832 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 26 1999 | | | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20x1

Page 1

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: [REDACTED]

CLASSIFICATION: [REDACTED]

EXEMPTION: [REDACTED]

REMARKS:

[REDACTED]

DATE: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

END

NOTE:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38165
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Glenn Edward Fisher

2. Date of Death

Month Day Year
November 18 1999

3. Time of Death

04:05 PM.

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

325-22-9297

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 27, 1924

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4105 Elby Street

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Albert L. Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Lena Towsley

19a. Informant's Name/Relationship (Type, Print)

Maxine Fisher/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4105 Elby Street, Silver Spring, Maryland 20906

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Nov. 23,
1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Robert A. Pumphrey

M00198

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. *Multiple Injuries*
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy
performed?

☒ Yes ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☒ Yes ☐ No

25. Was case referred to medical
examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☒ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
11/18/99

28b. Time of Injury

1535 M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Pedestrian Struck by vehicle
824 Interchange Drive Silver Spring, MD

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Parking lot

29a. Certifier
(Check one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Glenn Edward Fisher

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Fox Locke, Jr.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

B. Sparks

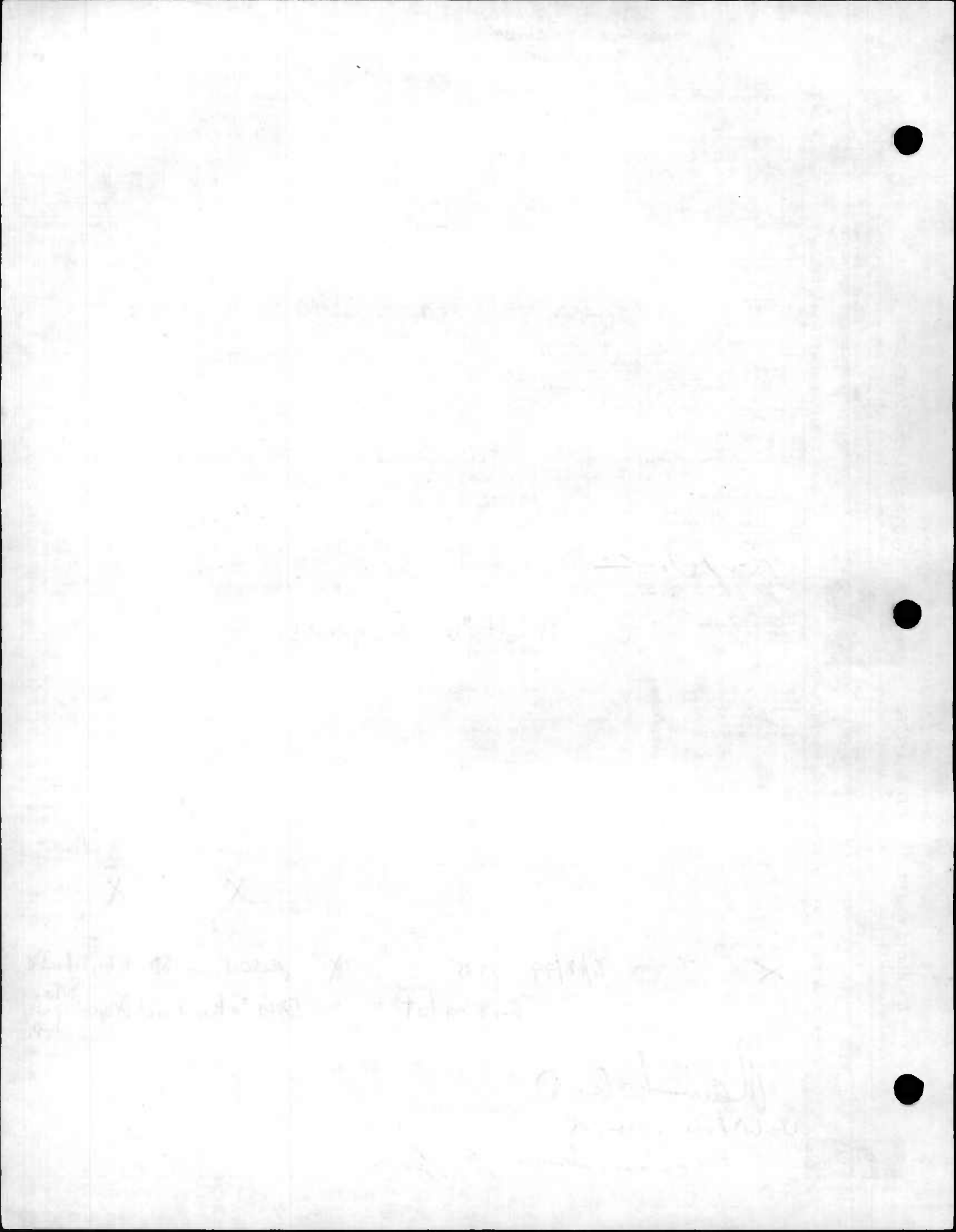
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 3053A.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38166

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MORRIS

FELDMAN

2. Date of Death

Month
NOV.Day
23,Year
1999

3. Time of Death

3:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3330 N. LEISURE WORLD BLVD. #915

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

067-24-6940

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
OCT. 8, 1912

9. Birthplace (State or Foreign Country)

ENGLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3330 N. LEISURE WORLD BLVD. #915

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FITTER

16b. Kind of Business/Industry

MEN'S CLOTHING

17. Father's Name (First, Middle, Last)

FRANK

FELDMAN

18. Mother's Name (First, Middle, Maiden Surname)

KATE

GOODMAN

19a. Informant's Name/Relationship (Type, Print)

GERTRUDE FELDMAN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

11/24/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Non Hodgkin's Lymphoma

Approximate Interval Between Onset and Death

6 yrs.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. W. Chambers MD

29c. License number

D 35635

29d. Date signed (Month, Day, Year)

NOV. 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, M.D. 18111 Prince Philip Dr. Suite 327, Olney, MD. 20832

State
Registrar

31. Date filed (Month, Day, Year)

NOV 26 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12-1-77 (82) 1000

12-1-77 (82) 1000 12-1-77 (82) 1000 12-1-77 (82) 1000

12-1-77 (82) 1000 12-1-77 (82) 1000 12-1-77 (82) 1000

12-1-77 (82) 1000 12-1-77 (82) 1000 12-1-77 (82) 1000

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12-1-77 (82) 1000 12-1-77 (82) 1000 12-1-77 (82) 1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38167

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FEREIDOUN FAKHARI

2. Date of Death

Month Day Year
NOVEMBER 20, 1999

3. Time of Death

3:57 A.M.

4a. Facility Name (If not Institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

225-73-9353

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAR. 23, 1922

9. Birthplace (State or Foreign Country)

IRAN

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11700 OWENS GLEN WAY

10f. Zip Code

20878

10g. Citizen of What Country?

IRAN

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 +

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PHYSICIAN

16b. Kind of Business/Industry

MEDICINE

17. Father's Name (First, Middle, Last)

TAGHI FAKHARI

18. Mother's Name (First, Middle, Maiden Surname)

MOLOUK (UNOBTAINABLE)

19a. Informant's Name/Relationship (Type, Print)

SHOKAT R. FAKHARI/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11700 OWENS GLEN WAY GAITHERSBURG, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GEORGE WASHINGTON CEM.

Date

11/22/99

20c. Location - City or Town, State

ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CARDIAC ARREST

Approximate
Interval Between
Onset and Death

MINUTES

Due to (or as a consequence of):

ISCHEMIC HEART DISEASE

25 YEARS

Due to (or as a consequence of):

ACUTE MYOCARDIAL INFARCTION

2 WEEKS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

c.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 39313

29d. Date signed (Month, Day, Year)

NOVEMBER 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLEN J. TAYLOR, M.D. 15225 SHADY GROVE ROAD ROCKVILLE, MARYLAND 20850

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3000.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38168

amend item 2 per phys. G787 9/1/00 yf

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) IDA GRAFMAN | | | | | | 2. Date of Death Month Day Year 11 22 21 99 | | 3. Time of Death 10:51 PM | |
| 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 418-62-6180 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) 1/26/1906 | | 9. Birthplace (State or Foreign Country) NEW YORK | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location BETHESDA | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 5101 RIDGEFIELD ROAD | | | | | | 10f. Zip Code 20816 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | |
| 17. Father's Name (First, Middle, Last) SAUL WEINSTEIN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROSA GOLDBERG | | | |
| 19a. Informant's Name/Relationship (Type, Print) STEPHEN GRAFMAN/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 BELLS MILL ROAD, POTOMAC, MARYLAND 20854 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ELMWOOD CEMETERY | | Data 11/24/99 | | 20c. Location - City or Town, State BIRMINGHAM, AL | |
| 21. Signature of Funeral Service Licensee Donald C. Stottmeyer | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADULT RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): b. PNEUMONITIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier Bernard A. Heckman, M.D. | | | | 29c. License number D05373 | | 29d. Date signed (Month, Day, Year) NOVEMBER 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD A. HECKMAN, M.D. 8830 CAMERON STREET, #405, SILVER SPRING, MD 20910 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature Bernard A. Sparks | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38169

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACOB GORDON

2. Date of Death

11/23/1999

Day Year

3. Time of Death

7:20 PM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579.38.4771

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06/03/1916

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10500 ROCKVILLE PIKE APT #1521

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WWII
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

PRIVATE PRACTICE

17. Father's Name (First, Middle, Last)

RUBEN GORDON

18. Mother's Name (First, Middle, Maiden Surname)

ALICE SCHREIBER

19a. Informant's Name/Relationship (Type, Print)

JEAN ELY GORDON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10500 ROCKVILLE PIKE APT #1521, ROCKVILLE, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS 11.26.99 FALLS CHURCH, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Multiple Myeloma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

7 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pheochromocytoma

Coronary artery disease

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Kanovsky MD

29c. License number

D29229

29d. Date signed (Month, Day, Year)

11/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin S. Kanovsky MD 5530 Wisconsin Ave #730 Chevy Chase MD 20815

31. Date filed (Month, Day, Year)

NOV 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

GORDON JACOB 11-23-99 7:20 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38170

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|--|--|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Beatrice Glazer | | | | 2. Date of Death Month November Day 19 , Year 1999 | | | | 3. Time of Death 11:45 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Woodside Center | | | | 4b. City, Town, or Location of Death Silver Spring | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 188-32-9676 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) March 3, 1905 | | 9. Birthplace (State or Foreign Country) New Jersey | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 9101 Second Ave. | | | | 10f. Zip Code 20910 | | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | | 16b. Kind of Business/Industry Education | | | | 17. Father's Name (First, Middle, Last) Charles Glazer | | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Ida Mintz | | | | 19a. Informant's Name/Relationship (Type, Print) Ilene Pollock/ Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Whitaker Tr. Silver Spring, MD. 20901 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial | | | | 20c. Location - City or Town, State Falls Church, VA. | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Stein Hebrew Memorial Funeral H. 232 Carroll St. NW. Washington, DC. 20012 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Liver Failure Due to (or as a consequence of): Chronic Hepatitis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> MD | | | | 29c. License number D11024 | | | | 29d. Date signed (Month, Day, Year) 11/22/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John Umhau, M.D. 8805 Connecticut Ave. Chevy Chase, MD. 20815 | | | | 31. Data filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

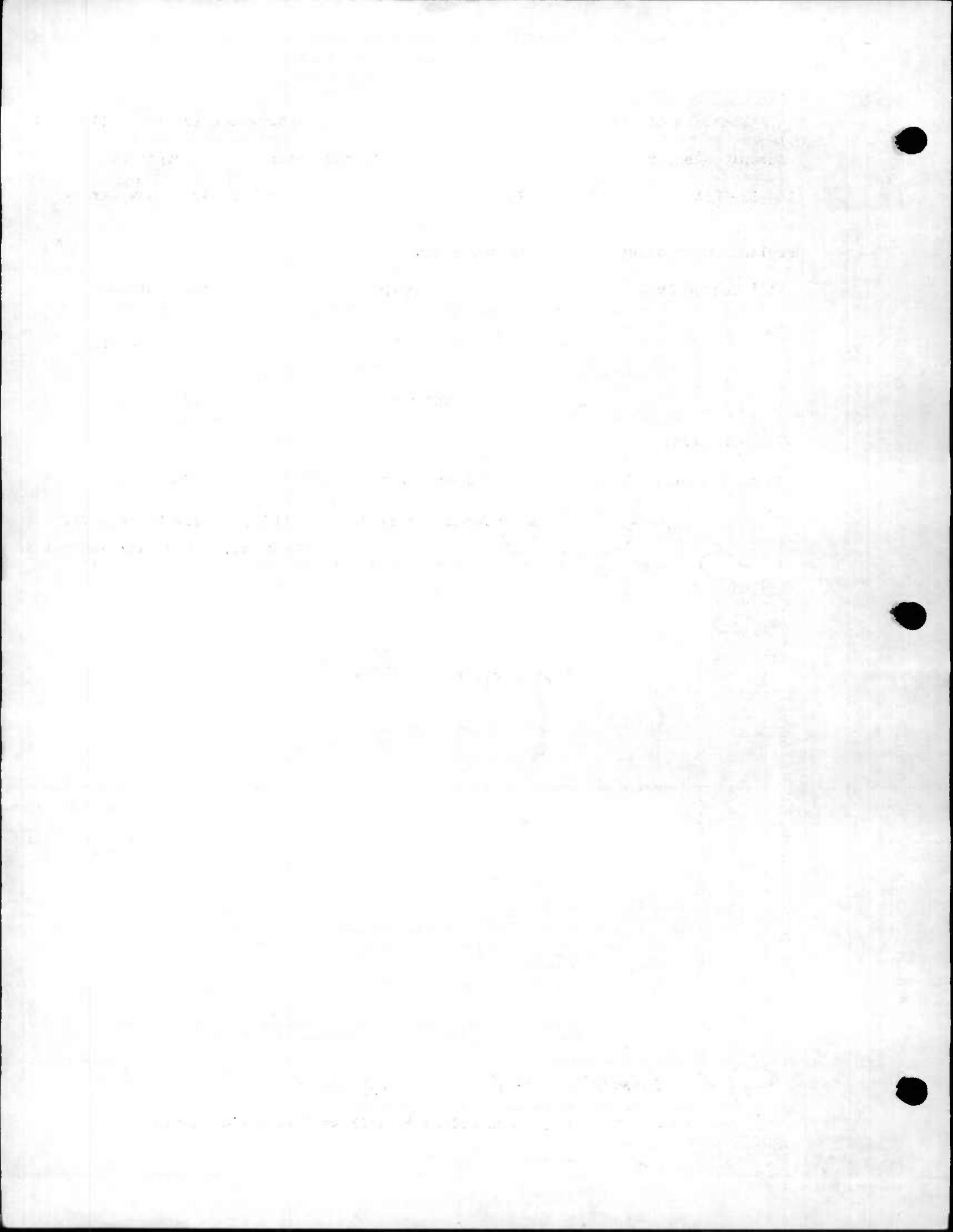
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular accident



amend item 29d per me
G780 2/18/00 yg

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38171

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lenchen F. Gerdes

2. Date of Death
Month Day Year
November 20, 1999

3. Time of Death
10:11 A.M.

4a. Facility Name (If not institution, give street and number)

932 Grandin Avenue

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

215-36-4814

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 8, 1922

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

932 Grandin Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Banker

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Fritz Martens

18. Mother's Name (First, Middle, Maiden Surname)

Mariechen Hanken

19a. Informant's Name/Relationship (Type, Print)

Wolfgang H. Gerdes/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

436 Egret Drive, Sunset Beach, North Carolina 28468

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Nov 23

1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Wolfgang H. Gerdes

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
M00803 Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Immediate

b. Coronary Artery Disease

Due to (or as a consequence of):

10+ Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

High Blood Pressure

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John S. Saia M.D.

29c. License number

M10493

29d. Date signed (Month, Day, Year)

23 November 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John S. Saia, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68780,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-1000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

part 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38172
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Nancy Krokene Gagne | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 6:00 PM | |
| 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing & Rehab. Center | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 114-09-7733 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar 7, 1910 | |
| 9. Birthplace (State or Foreign Country) Norway | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Derwood | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 14 Millcrest Court | | 10f. Zip Code 20855 | | 10g. Citizen of What Country? Norway | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Assembler | | 16b. Kind of Business/Industry Electronics | | | |
| 17. Father's Name (First, Middle, Last) Johan Krokene | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ragna Thisefest | | | |
| 19a. Informant's Name/Relationship (Type, Print) Roger Gagne, son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Millcrest Court Derwood, MD 20855 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Date Nov 22, 1999 | | 20d. Location - City or Town, State Alexandria, VA | |
| 21. Signature of Funeral Service Licenses Robert H. DeVol | | | | 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 20 YEARS | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEHYDRATION | | 23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | |
|--|--|--|--|
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier Jonathan S. Plotsky M.D. | | 29c. License number D38589 | |
| 29d. Date signed (Month, Day, Year) November 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan S. Plotsky, M.D., 15225 Shady Grove Road, #208 Rockville, MD 20852 | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature B. Sparks | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5/11/81

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38173

Amended item #10b, 11/19/99, E.T, WCHD

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>George Giddins</i> | | | | 2. Date of Death Month <i>Nov</i> Day <i>15</i> Year <i>1999</i> | | 3. Time of Death <i>11:55 A</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Clinton</i> | | 4c. County of Death <i>Montgomery</i> | |
| Funeral Director | 5. Social Security Number <i>230-34-7044</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>74</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>May 5, 1925</i> | 9. Birthplace (State or Foreign Country) <i>Virginia</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <i>Maryland</i> | | 10b. County <i>Prince George's</i> | | 10c. City, Town or Location <i>Upper Marlboro</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number <i>9908 Welshire Drive</i> | | | | 10f. Zip Code <i>20772</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Foreman</i> | | 16b. Kind of Business/Industry <i>Poultry Factory</i> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <i>George Edward Giddins</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Scarborough</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Glenda G. Mason, Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9908 Welshire Drive Upper Marlboro, Md. 20772</i> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bethel Baptist Church</i> | | Date <i>11/20/99</i> | | 20c. Location - City or Town, State <i>Franktown, Virginia</i> | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility <i>John O. Morris Funeral Home 6328 Lanford Hwy. P.O. Box 175 Nassawadox, Va. 23413</i> | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) <i>a. Congestive Heart Failure</i> | | | | | | | <i>months</i> |
| | Due to (or as a consequence of): <i>b. Coronary Artery Disease</i> | | | | | | | <i>years</i> |
| | Due to (or as a consequence of): <i>c. </i> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. <i>Arteriosclerosis, Atrial Fibrillation</i> | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | <i>Chronic Lung Disease</i> | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number <i>D26352</i> | | 29d. Date signed (Month, Day, Year) <i>Nov 15 1999</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>OL Hays 9131 Cassaway Rd Clinton Md 20735</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>NOV 19 1999</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38174

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Virginia Huntington

2. Date of Death
Month Day Year
November 19, 1999

3. Time of Death
2:15 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-60-0867

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 15, 1915

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3000 McComas Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

supervisor

16b. Kind of Business/Industry

F.B.I.

17. Father's Name (First, Middle, Last)

Charles F. Huntington

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Burrows

19a. Informant's Name/Relationship (Type, Print)

Bettie J. Gerachis/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3130 Wisconsin Ave., N.W., Washington, DC 20016 #209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

Nov. 23, 99 Washington, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James E. B. [Signature]

22. Name and Address of Facility

DeVol Funeral Home
2222 Wisconsin Ave., N.W., Wash., DC 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D00053528

29d. Date signed (Month, Day, Year)

Nov. 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daphna Henkin, M.D., 2309 Shorefield Road, Wheaton, Md.

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-524-2028.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

32

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38175

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Peggy Edwards Hughes

2. Date of Death

November 20, 1999

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

234-68-4289

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 18, 1944

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7817 Hampden Lane

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Arbie Obel Edwards

18. Mother's Name (First, Middle, Maiden Surname)

Alice Burgess

19a. Informant's Name/Relationship (Type, Print)

John Vance Hughes/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7817 Hampden Lane, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Nov. 22, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic breast cancer

Due to (or as a consequence of):

b. adenocarcinoma of breast

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one year

four years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D21531

29d. Date signed (Month, Day, Year)

Nov. 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Peter Pushkas, M.D. 11510 Old Georgetown Road, Rockville, Maryland 20852

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 99 38176

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ESTELLE HORN | | | | 2. Date of Death Month 11 Day 18 Year 99 | | 3. Time of Death 1:30 PM | |
| 4a. Facility Name (If not Institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 051-20-8012 | | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 6. Date of Birth (Month, Day, Year) 12/15/1907 | |
| 9. Birthplace (State or Foreign Country) WARSAW, POLAND | | Usual Residence of Decedent | | 10a. State MD | | 10b. County MONTGOMERY | |
| 10c. City, Town or Location BETHESDA | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 9913 MARQUETTE DRIVE | | 10f. Zip Code 20817 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | 16b. Kind of Business/Industry CITY OF NEW YORK | |
| 17. Father's Name (First, Middle, Last) HARRY WARSHAFSKY | | | | 18. Mother's Name (First, Middle, Maiden Surname) CIPA BECHT | | | |
| 19a. Informant's Name/Relationship (Type, Print) LORETTA GREENBERG / DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9913 MARQUETTE DRIVE BETHESDA, MARYLAND 20817 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH MOSES PINELAWN CEMETERY | | 20c. Location - City or Town, State 11/21/99 LONG ISLAND, NY | | 21. Signature of Funeral Service licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 | |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STROKE | | | | | | Approximate Interval Between Onset and Death 15 HRS | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Gregory A. Compton MD | | 29c. License number D24942 | | 29d. Date signed (Month, Day, Year) Nov 18 1999 | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Gregory A. Compton MD 6121 Montrose Rd Rockville, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

30

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene 99 38177

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul L. Horecky

2. Date of Death
Month Day Year
November 17, 19993. Time of Death
12:15 pmFuneral
Director

4a. Facility Name (If not institution, give street and number)

Collington Episcopal Lifecare Center

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

5. Social Security Number

226-56-5609

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 13, 1913

9. Birthplace (State or Foreign Country)

Czechoslovakia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10450 Lottsford Road, #206

10f. Zip Code

20721-2734

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

Chief Slavic Division
Library of Congress

17. Father's Name (First, Middle, Last)

Fritz Horetzky

18. Mother's Name (First, Middle, Maiden Surname)

Else Weiner

19a. Informant's Name/Relationship (Type, Print)

Frederick J. Horecky (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 4112, Agana, Guam 96932

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

11/21/99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licenses

M00956

22. Name and Address of Facility Rapp Funeral & Cremation Services,

Stephen D. Lohrmann, P.A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypersension, Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25079

29d. Date signed (Month, Day, Year)

November 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don H. Yoblonowitz, M.D., 7404 Executive Place, #502, Seabrook, Maryland 20706

State
Registrar

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

James B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

09 38178

Amend#20a,b,c,-11/29/99,BMW, Montg.Co.

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|--|--|---|--------------------------------|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MORRIS HOFFMAN | | | | 2. Date of Death Month 11 Day 23 Year 99 | | 3. Time of Death 3:30 PM | | |
| | 4a. Facility Name (If not Institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 135-18-5563 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 2/1/1911 | 9. Birthplace (State or Foreign Country) NEW YORK | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1801 EAST JEFFERSON STREET #324 | | | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UPOLSTERER | | 16b. Kind of Business/Industry SELF-EMPLOYED | | | | |
| | 17. Father's Name (First, Middle, Last) JOSEPH HOFFMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) UNACERTAINABLE | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) DR. RONALD HOFFMAN/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1962 NORTH FREEMONT, CHICAGO, IL 60614 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, funeral home, or place) King David Men's Gardens ETERNAL LIGHT MEMORIAL GARDENS | | Date 11/26/99 | | 20c. Location - City or Town, State Fals Church, Virginia BOYNTON BEACH, FL | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier | | | | 29c. License number D18084 | | 29d. Date signed (Month, Day, Year) NOVEMBER 23, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D-D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38179

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|-----------------------------|--|--|--|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) James Leslie Hill | | | | 2. Date of Death Month Day Year NOVEMBER 21, 1999 | | | | 3. Time of Death 21:05 PM | |
| | 4a. Facility Name (If not institution, give street and number) 9511 DUFFER WAY | | | | 4b. City, Town, or Location of Death Gaithersburg | | | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 381-54-1996 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) June 11, 1940 | | 9. Birthplace (State or Foreign Country) Canada | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 9511 Duffer Way | | 10f. Zip Code 20879 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Biostatistician | | 16b. Kind of Business/Industry National Institutes of Health | | | | | |
| | 17. Father's Name (First, Middle, Last) James Leslie Hill | | | | 18. Mother's Name (First, Middle, Maiden Surname) Paulette Marie Slupsky | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Andrea M. Hill/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Princess Street, Apt. 2, Kingston, Ontario, Canada K7L1A8 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | Data Nov. 24, 1999 | | 20c. Location - City or Town, State Bethesda, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  M01126 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed? Limited 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) NOVEMBER 22, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38180

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Janis S. Hickok | | | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 11:30AM | |
| | 4a. Facility Name (If not institution, give street and number) Casey House | | | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 232-70-8322 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 3, 1944 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Montgomery Village | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 9742 Duffer Way | | | | 10f. Zip Code 20886 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 16b. Kind of Business/Industry Corporate Law | | | |
| 17. Father's Name (First, Middle, Last) Frank Sanford | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Brown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John Thomas Hickok/Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9742 Duffer Way, Montgomery Village, Maryland 20886 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | | Date Nov 24 1999 | | 20c. Location - City or Town, State Bethesda, Maryland | | |
| 21. Signature of Funeral Service Licensee David E. Perry | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Leukemia (Probable Acute Myelogenous Leukemia) Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 1 Month |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Mark S. Godec, MD | | | | | | 29c. License number D37620 | | 29d. Date signed (Month, Day, Year) November 21, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Godec, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38181

Amend #5, 12, 11/30/99, JW, Montg. County

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Trent Hensel | | | | 2. Date of Death Month Day Year November 22 1999 | | 3. Time of Death 9:31 AM | |
| | 4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital | | | | 4b. City, Town, or Location of Death Lanham | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 213-30-0381 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Apr. 24, 1935 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Greenbelt | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 19C Parkway | | | 10f. Zip Code 20770 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1958 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Firefighter | | 16b. Kind of Business/Industry Washington, D.C. | | | |
| | 17. Father's Name (First, Middle, Last) Francis Hensel | | | 18. Mother's Name (First, Middle, Maiden Surname) Eileen McCaffrey | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Irene B. Hensel (wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Orange Court Greenbelt, Maryland 20770 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 11/27/1999 Alexandria, Virginia | | | 20c. Location - City or Town, State | | |
| | 21. Signature of Funeral Service Licensee Donald V. Borgwardt | | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive Gastrointestinal Hemorrhage Due to (or as a consequence of): b. Cardiorespiratory Arrest Due to (or as a consequence of): c. Acute Hypotension Due to (or as a consequence of): d. Coronary Artery Disease | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner | | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 29205 | | | | | | |
| 29b. Signature and title of certifier Dr. Felipe Robinson MD | | 29c. License number D 29205 | | 29d. Date signed (Month, Day, Year) 11/23/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FELIPE ROBINSON, MD 7715 BELLE POINT DRIVE, GREENBELT, MD 20770 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature Anna B. Sparks | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

1. Study the wall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38182

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN L. HARRIS

2. Date of Death

Month Day Year
NOV. 20, 1999

3. Time of Death

11:55 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

577-52-9287

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 14, 1914

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

602 UNIVERSITY BLVD. E.

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

DIETARY WORKER

16b. Kind of Business/Industry

ST. ELIZABETH'S HOSPT.

17. Father's Name (First, Middle, Last)

GRIFFIN

RICHARDSON

18. Mother's Name (First, Middle, Maiden Surname)

IRENE

FRANKLIN

19a. Informant's Name/Relationship (Type, Print)

ERNESTINE L. HARRIS/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

11/23/99

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers MO0091

22. Name and Address of Facility

20906 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Infected decubitus ulcer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Dipinder Singh MD

29c. License number

D45660

29d. Date signed (Month, Day, Year)

Nov. 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300, GALLAN FOX

DR. DIPINDER SINGH, MD.

CN Suite 124, Bowie MD 20715

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

• • • • •

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38183**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Elizabeth N. Harris
2. Date of Death Month Day Year November 19, 1999
3. Time of Death 1:30 am

Funeral
Director

4a. Facility Name (If not institution, give street and number) Manor Care- Chevy Chase
4b. City, Town, or Location of Death Chevy Chase
4c. County of Death Montgomery

5. Social Security Number 577-03-5352
6. Sex ☐ M ☒ F
7. Age (In yrs. last birthday) 91 Yrs.
8. Date of Birth (Month, Day, Year) Sept 29, 1908
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State Maryland
10b. County Montgomery
10c. City, Town or Location Silver Spring
10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 2201 Colston Drive, Apt 300
10f. Zip Code 20910
10g. Citizen of What Country? USA

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) Secretary
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry Federal Government

17. Father's Name (First, Middle, Last) John Francis Norris
18. Mother's Name (First, Middle, Maiden Surname) Ada Lucy Norris

19a. Informant's Name/Relationship (Type, Print) John Harris / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 Haviland Drive, Bethesda, MD 20817

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery
Date Nov 22 1999
20c. Location - City or Town, State Washington, DC

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Francis J. Collins Funeral Home, Inc.
500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Lymphoma
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Ellen Pinholt-MD
29c. License number D51015
29d. Date signed (Month, Day, Year) November 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen Pinholt, M.D. 5530 Wisconsin Ave., #1045 Chevy Chase, MD 20815

State
Registrar

31. Date filed (Month, Day, Year) NOV 22 1999
32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38184

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Lucile Holthaus

2. Date of Death
Month Day Year

Nov. 16th 1999

3. Time of Death

2:57 pm

4a. Facility Name (If not institution, give street and number)

Carroll Lutheran Village Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

220-50-4744

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct 21 1910

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 St. Mark Way

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Dr. Ernest A. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Deborah Thorpe

19a. Informant's Name/Relationship (Type, Print)

Gay McCormick/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

62 Ridge Rd Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bixlers Church Cem

Date

11/23/99 Westminster, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel

412 Washington Rd Westminster, MD 21157

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 wk

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Rheumatoid Arthritis, Second Dependent

Gastro paresis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37949

29d. Date signed (Month, Day, Year)

Nov. 17th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Bogdanovskiy 205 St. Mark Way Westminster MD 21157

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

Kenna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-2024.

Physician
/Medical
Examiner

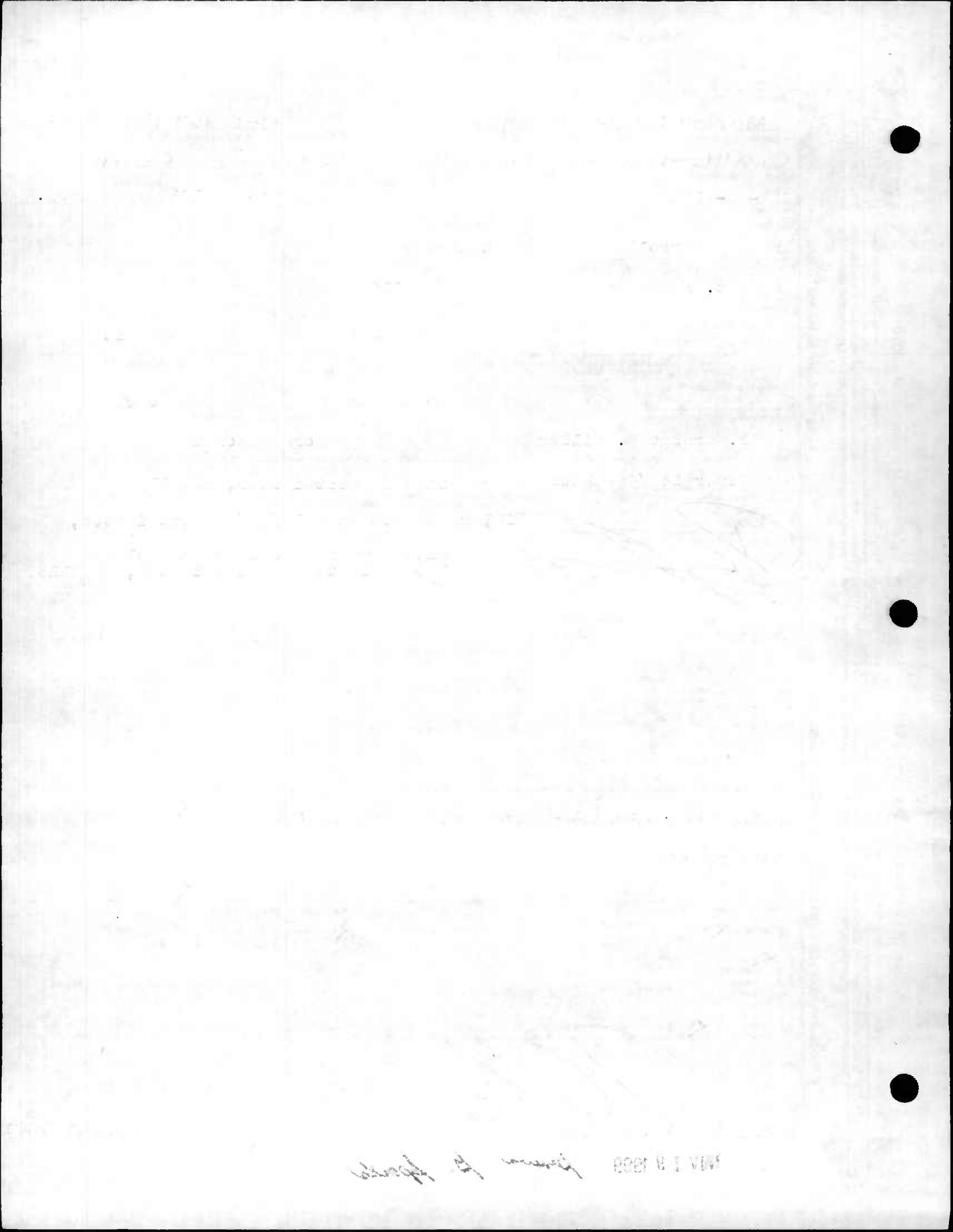
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



[Faint signature/initials]

COPY 11 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#4a perPhyG778 12/20/99 EW
 State of Maryland / Department of Health and Mental Hygiene 99 38185
 AMEND#10e PER F.H.G778 12-14-99 J.A. Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Thomas Joseph Judge | | 2. Date of Death Month November Day 20 Year 1999 | | 3. Time of Death 11:55P. | |
| 4a. Facility Name (If not institution, give street and number) 1205 Gwynne Avenue | | 4b. City, Town, or Location of Death Churchton | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 156-22-0548 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 22, 1931 |
| 9. Birthplace (State or Foreign Country) New Jersey | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Churchton | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1205 Gwynne Avenue | | 10f. Zip Code 20733 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-1954 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ink Formulator | | 16b. Kind of Business/Industry Capital Printing Inc. | |
| 17. Father's Name (First, Middle, Last) John Henry Judge | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Webb | | | |
| 19a. Informant's Name/Relationship (Type, Print) Kathleen Fenstermaker (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12044 Suffolk Terrace Gaithersburg, Maryland 20878 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 11/24/1999 Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i> | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u><i>lung cancer, metastatic</i></u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death 9 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Berez MD</i> | | 29c. License number D0029571 | | 29d. Date signed (Month, Day, Year) November 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Berez, M.D. 1655 Crofton Blvd., #101 Crofton, Maryland 21114 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature <i>Beverly B. Sparks</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permi. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38186

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Holden Justi Sr.

2. Date of Death
Month Day Year

November 23, 1999

3. Time of Death

10:45p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Kent & Queen Anne's Hospital Inc.

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

705-09-4977

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

April 15, 1900

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

102 Royston Shore Road

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Chief Clerk

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Charles Lewis Justi

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Williamson

19a. Informant's Name/Relationship (Type, Print)

William Holden Justi, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 375, Reedville, Virginia 22539

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center, LLC 11/26/99 Stevensville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.

130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Rupture Abdominal Aortic Aneurysm.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 minute.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SSS. Paroxysmal Afib/Aflutter/BBB/H Tn/ASCVD.

Sp PTCA / BPH / Mx Subdural Hematoma / Diverticulitis.

Arthritis/Osteoporosis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 50996

29d. Date signed (Month, Day, Year)

11/23/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10 Neil Stoddard, 100 Brown Street, Chestertown, Maryland 21620

State
Registrar

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 3 1938

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38187

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH EDWARD KRAL

2. Date of Death
Month Day Year

11

20

99

3. Time of Death

15:50

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

DORCHESTER GENERAL HOSPITAL

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

5. Social Security Number

214-07-9020

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

OCT. 24, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

SECRETARY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

102 MYRTLE STREET

10f. Zip Code

21664

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ASSEMBLY LINE WORKER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

JOSEPH FRANK KRAL

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE MOXEY

19a. Informant's Name/Relationship (Type, Print)

SARA B. KRAL/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. BOX 123, SECRETARY, MARYLAND 21664

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OUR LADY OF GOOD COUNSEL

Date

11/23

20c. Location - City or Town, State

SECRETARY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207,
106 MAIN STREET, EAST NEW MARKET, MD 2163123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Transitional Cell Ca of Bladder
Due to (or as a consequence of):

One week

b. Congenive Cardiomyopathy
Due to (or as a consequence of):

10 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident 6 ☐ Could not be
3 ☐ Suicide 6 ☐ determined
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28b. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D15541

29d. Date signed (Month, Day, Year)

11/21/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

VINODRAI MEHTA, M.D., 400 AURORA STREET, CAMBRIDGE, MD 21613

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 Ldb
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
2025



James L. [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38188

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHYLLIS SOKOLOWSKY KURITZKY

2. Date of Death

Month Day Year
11 18 99

3. Time of Death

10:40 PM

4a. Facility Name (If not institution, give street and number)

5403 MAD RIVER LANE

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

128-22-5987

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

5/11/1931

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5403 MAD RIVER LANE

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SOCIAL WORKER

16b. Kind of Business/Industry

NEW YORK STATE

17. Father's Name (First, Middle, Last)

MAX SOKOLOWSKY

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER NEVINS

19a. Informant's Name/Relationship (Type, Print)

SIMCHA KURITZKY/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1220 BLAIR MILL ROAD #605 SILVER SPRING, MD 21910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

11/21/99

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. OVARIAN CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D41139

29d. Date signed (Month, Day, Year)

NOVEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLEMENT B. KNIGHT 11605 LITTLE PATUXENT PKWY COLUMBIA, MARYLAND 21044

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38189

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---------------------------|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William L. Koperwas | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 6:15 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) The Hebrew Home of Greater Washington | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 577-36-8390 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 17, 1921 | | 9. Birthplace (State or Foreign Country) Poland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 8600 16th St. #203 | | | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman | | | 16b. Kind of Business/Industry Retail | | | |
| 17. Father's Name (First, Middle, Last) Israel Koperwas | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mar Kowicz | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Shirley Greenbaum/sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9813 Holmhurst Rd. Bethesda, MD. 20817 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Beth Shalom Cong. Cemetery | | | Date 11/23 | | 20c. Location - City or Town, State Capital Heights, MD. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stein Hebrew Funeral Home. 232 Carroll St. NW. Washington, DC. 20012 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADENOCARCINOMA OF COLON Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 YEAR | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D18084 | | | 29d. Date signed (Month, Day, Year) NOVEMBER 21, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dineshbhai Patel, MD. 6121 Montrose Rd. Rockville, MD. 20852 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WYOMING

SECTION 36, T.14N. R.10E. S.10E.

WYOMING

SECTION 36, T.14N. R.10E. S.10E.

WYOMING

SECTION 36, T.14N. R.10E. S.10E.

WYOMING

SECTION 36, T.14N. R.10E. S.10E.

WYOMING

SECTION 36, T.14N. R.10E. S.10E.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38190

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Claire Patricia Kerstetter

2. Date of Death

November 24, 1999

3. Time of Death

4:40 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-36-1394

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 5, 1922

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15316 Manor Village Lane

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Colin Joseph Chisholm

18. Mother's Name (First, Middle, Maiden Surname)

Ann May Campbell

19a. Informant's Name/Relationship (Type, Print)

Dale D. Kerstetter/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15316 Manor Village Lane, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Nov 29 1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Ken Skiles

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of)

immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery atherosclerosis

Due to (or as a consequence of)

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypoglycemic coma hours before death

Extensive severe osteoporosis

Extensive arthritis secondary to above

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard P. Delaney, MD

29c. License number

DO 2338

29d. Date signed (Month, Day, Year)

11/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD P. DELANEY, MD, 3129 FERARRA DR. SILVER SPRING, MD 20904

31. Date filed (Month, Day, Year)

NOV 26 1999

32. Registrar's Signature

Barbara B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38191
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|--|---------------------------------|--|--|--|--------------------------------|---|--|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANKISS EUGENE LOGUE | | | | 2. Date of Death Month 11 - Day 23 - Year 99 | | | | 3. Time of Death 0800 | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | 4b. City, Town, or Location of Death Cambridge | | | | 4c. County of Death Dorchester | | | | | | |
| Funeral Director | 5. Social Security Number 219-30-2772 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 65 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Sept 29, 1934 | | 9. Birthplace (State or Foreign Country) Washington, DC | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State Maryland | | | | 10b. County Dorchester | | | | 10c. City, Town or Location Cambridge | | | | 10d. Inside City Limits 1 Yes 2 No | | | |
| 10e. Street and Number 6010 Todd Point Road | | | | | | 10f. Zip Code 21613 | | | | 10g. Citizen of What Country? US | | | | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipefitter/Foreman | | | | 16b. Kind of Business/Industry Steel Mill | | | | | |
| 17. Father's Name (First, Middle, Last) Eugene Logue | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Daniel | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Paula T. Logue Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6010 Todd Point Road Cambridge, Maryland 21613 | | | | | | | | | |
| 20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | | | Date 11/24/99 | | 20c. Location - City or Town, State Salisbury, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | | | Approximate Interval Between Onset and Death 2 YR | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 <input checked="" type="checkbox"/> Probably 4 Unknown | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number D33622 | | 29d. Date signed (Month, Day, Year) 11-23-99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRAG CALDWELL MD 2 AURORA ST, CAMBRIDGE, MD | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | | | 32. Registrar's Signature | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38192

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Betty Lucille Lovins | | | | | 2. Date of Death Month Day Year November 16, 1999 | | 3. Time of Death 1335 |
| | 4a. Facility Name (If not institution, give street and number) 5903 Ryland Drive | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 281-16-8095 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 25, 1920 | | 9. Birthplace (State or Foreign Country) Kentucky |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5903 Ryland Drive | | | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 16b. Kind of Business/Industry Union | |
| 17. Father's Name (First, Middle, Last) Wiley C. Tipton | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nell Simms | | | |
| 19a. Informant's Name/Relationship (Type, Print) Raymond Earl Lovins/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5903 Ryland Drive, Bethesda, Maryland 20817 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | Date Nov. 23, 1999 | | 20c. Location - City or Town, State Cheltenham, Maryland | | |
| 21. Signature of Funeral Service Licensee  M00198 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extensive Small Cell Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 6 weeks |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D37236 | | 29d. Date signed (Month, Day, Year) November 18, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks, M.D. 6410 Rockledge Drive #305, Bethesda, Maryland 20817 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | |

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38193

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | |
|--|--|---|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) Ella Mae Looney | | 2. Date of Death Month 11 - Day 18 - Year 99 | | 3. Time of Death 0343A |
| 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George's |
| 5. Social Security Number 579-34-4074 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) May 25, 1927 | | 9. Birthplace (State or Foreign) Virginia | | |
| Usual Residence of Decedent | | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Beltsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 4404 Tonquil Place | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? United States |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker | | |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry own home | | |
| 17. Father's Name (First, Middle, Last) Frank E. Atkins | | 18. Mother's Name (First, Middle, Maiden Surname) Frieda Dodson | | |
| 19a. Informant's Name/Relationship (Type, Print) Sheila Harper (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16950 Old Frederick Road Mt. Airy, Maryland 21771 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | 20c. Location - City or Town, State 11/20/1999 Brentwood, Maryland |
| 21. Signature of Funeral Service Licensee Donald V. Borgwardt | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. ANEMIA, CONSUMPTIVE COAGULopathy c. Peptic Ulcer Disease Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Adult onset Diabetes Mellitus ANEMIA, CONSUMPTIVE COAGULopathy Peptic Ulcer Disease | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier William A. Warren | | 29c. License number 213916 | | 29d. Date signed (Month, Day, Year) November 18, 1999 |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) William A. Warren 301 Prince George St Laurel, Md 20707 | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature Barbara B. Sparks | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

State
Registrar

ASAC - PP - 212 A
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ASAC - PP - 212 BU
ASAC - PP - 212 BV
ASAC - PP - 212 BW
ASAC - PP - 212 BX
ASAC - PP - 212 BY
ASAC - PP - 212 BZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38194

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH GERHARDT LIPFERT

2. Date of Death

Month

Day

Year

NOV

18

1999

3. Time of Death

12:53 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

176-32-4604

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 8, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9102 Drumaldry Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

17. Father's Name (First, Middle, Last)

Jesse A. Lipfert

18. Mother's Name (First, Middle, Maiden Surname)

Frieda Kleinau

19a. Informant's Name/Relationship (Type, Print)

Gloria Hall Lipfert/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9102 Drumaldry Drive, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

Nov. 29, 1999

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Ray

M00198

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carolyn McMonigle MD

29c. License number

40812-020 (WI)

29d. Date signed (Month, Day, Year)

11/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN C. MCMONIGLE, LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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15+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38195

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) ESTELLE LINER | | | | 2. Date of Death Month 11 Day 21 Year 99 | | 3. Time of Death 10:15 AM | |
| 4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number 168-32-3283 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 3/6/1917 | |
| 9. Birthplace (State or Foreign Country) PA | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location KENSINGTON | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3618 LITTLEDALE ROAD | | | | 10f. Zip Code 20895 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | |
| 17. Father's Name (First, Middle, Last) SAMUEL HOFFMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROSE LIPSHUTZ | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARILYN MADDEN/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17509 APPLEWOOD LANE, ROCKVILLE, MARYLAND 20855 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND FREESTATE CEMETERY | | Date 11/23/99 | | 20c. Location - City or Town, State GARRISON, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DEMENTIA, VASCULAR Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D18084 | | 29d. Date signed (Month, Day, Year) NOVEMBER 21, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.D. PATEL, MD 614 MONTROSE RD Rockville, MD 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

99 38196

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38197

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Olwen Millet

2. Date of Death

November 20, 1999

3. Time of Death

11:50 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-40-4002

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 17, 1916

9. Birthplace (State or Foreign Country)

Quebec, Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12304 Clement Lane

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

George Smith

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Evans

19a. Informant's Name/Relationship (Type, Print)

Jo Ann Peters (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12304 Clement Lane Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

11/22/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

P. Ryan M. Millet

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disseminated Intravascular Coagulopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

b. Hypothyroid Coma

Due to (or as a consequence of):

3 days

c. Severe Myxedema

Due to (or as a consequence of):

weeks

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard P. Delaney, M.D.

29c. License number

D 02338

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard P. Delaney, M.D. 3923 Ferrara Drive Silver Spring, Maryland 20906

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

99 38198

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THOMAS ELIJAH MILLER, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 21, 1999 | | 3. TIME OF DEATH 10:20 A M | |
| 4. SOCIAL SECURITY NUMBER 538-24-2539 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr. 13, 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) VA. | | | | 9a. FACILITY NAME (If not institution, give street and number) 7502 Lenham Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Ft. Washington | |
| 9c. COUNTY OF DEATH Prince Georges | | | | 10a. STATE MD | | 10b. COUNTY Prince Georges | |
| 10c. CITY, TOWN OR LOCATION Ft. Washington | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7502 Lenham Drive | |
| 10f. ZIP CODE 20744 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1942 - 1946 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last) Elijah Miller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Delilah Cardwell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thomas Miller, Jr. - Son | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7502 Lenham Dr., Ft. Washington, MD 20744 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery 11/21/99 | | 20c. LOCATION — City or Town, State Washington, DC | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N.W., DC, 20011 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 1 year Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D20352 | | 29d. DATE SIGNED (Month, Day, Year) 11-23-99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARRY Z. KATZNER 8926 Woodward Rd Clinton MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) NOV 24 1999 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38199

Amend #8, 12/3/99, BMW, Montg. Co.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James King Meyers

2. Date of Death
Month Day Year

November 24, 1999

3. Time of Death

9:30 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-18-3108

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

July 30, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

North Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10201 Grosvenor Place Apt 1111

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Voice of America

17. Father's Name (First, Middle, Last)

Joseph Herman Meyers

18. Mother's Name (First, Middle, Maiden Surname)

Catherine King

19a. Informant's Name/Relationship (Type, Print)

Ruby G. Meyers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10201 Grosvenor Place Apt 1111, North Bethesda, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Data

Nov 27
1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

J. Ken Skile

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ventricular fibrillation

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

48 hours

b. Acute myocardial infarction

Due to (or as a consequence of):

48 hours

c. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

12 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Yuri A. Deychak

29c. License number

D16360

29d. Date signed (Month, Day, Year)

November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yuri Deychak, M.D. 6410 Rockledge Dr., Bethesda, MD 20817

State
Registrar

31. Date filed (Month, Day, Year)

NOV 26 1999

32. Registrar's Signature

Bernice B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38200

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRADLEY STEVEN MARGGRAF

2. Date of Death
Month Day Year
NOVEMBER 18, 19993. Time of Death
5:05 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

216 88 2260

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 29, 1962

9. Birthplace (State or Foreign Country)

TEXAS

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

GERMANTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29 APPLEGRATH COURT

10f. Zip Code

20876

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SUPERINTENDENT

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ROBERT E. MARGGRAF

18. Mother's Name (First, Middle, Maiden Surname)

PATRICIA RAE FANNIN

19a. Informant's Name/Relationship (Type, Print)

MARY MORAN MARGGRAF, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 APPLEGRATH COURT, GERMANTOWN, MD. 20876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

11/21/99

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

90 MIN.

Due to (or as a consequence of):

b. ASYSTOLE - ARRHYTHMIA - P.E.A.

90 MIN.

Due to (or as a consequence of):

c. CHEST PAIN

6 HRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Muriel H. Barber MD

29c. License number

53601

29d. Date signed (Month, Day, Year)

NOVEMBER 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHSIN IJAZ, M.D. 11119 ROCKVILLE PIKE, #100, ROCKVILLE, MD. 20852

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38201

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond F. Noyes

2. Date of Death

November 19, 1999

3. Time of Death

3:10 am

4a. Facility Name (If not Institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-26-0819

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 26, 1914

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

362 Park Street, NE

10f. Zip Code

22180

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Congressional Record Clerk

16b. Kind of Business/Industry

Government Printing

17. Father's Name (First, Middle, Last)

Benjamin Franklin Noyes

18. Mother's Name (First, Middle, Maiden Surname)

Julia Ellen Trunnel

19a. Informant's Name/Relationship (Type, Print)

Lawrence R. Noyes / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

362 Park Street, NE, Vienna, VA 22180

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

Nov 22 1999

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

Mark P. Pineda

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

3 days

b. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Idiopathic thrombocytopenic purpura

Demantia

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M.D.

29c. License number

D00053528

29d. Date signed (Month, Day, Year)

November 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daphna Henkin, M.D. 2309 Shorefield Rd. Wheaton, MD 20902

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38202

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ESTHER MALOBA NGOH | | | | 2. Date of Death Month Day Year NOV. 21, 1999 | | 3. Time of Death 4:46 AM | |
| 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death OLNEY | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number NONE | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 10, 1934 | |
| 9. Birthplace (State or Foreign Country) MALENDIA, KUMBA | | 10a. State CAMEROON | | 10b. County NONE | | 10c. City, Town or Location KUMBA | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number P.O. BOX 141 | | 10f. Zip Code NONE | | 10g. Citizen of What Country? CAMEROON | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry HOME | | 17. Father's Name (First, Middle, Last) ESAMBI NGOH | |
| 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH MUSONGO | | 19a. Informant's Name/Relationship (Type, Print) ABEL NGOH/GRANDSON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3634 BEL PRE RD. #24, SILVER SPRING, MD. 20906 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) MALENDIA CEMETERY | | 20c. Date 12/3/99 | | 20d. Location - City or Town, State MALENDIA, KUMBA | | 21. Signature of Funeral Service Licensee M. W. Chambers M00091 | |
| 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Acute myocardial infarction Due to (or as a consequence of): f. Coronary Artery disease Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 1 day 2 years | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier Amenudhu | | 29c. License number D38262 | | 29d. Date signed (Month, Day, Year) Nov 21, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Mendhiratta 2401 Research Blvd Suite 340 Rockville MD 20854 | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature B. Sparks | | 33. State Registrar | | 34. State Registrar | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

100-100000-100000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38203

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES C. OTIS, JR | | | | 2. Date of Death Month Day Year Nov. 21 1999 | | 3. Time of Death 1657 | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 121-12-2612 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 19, 1915 | 9. Birthplace (State or Foreign Country) Vermont |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Germantown | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 14613 Brookmead Drive | | | | 10f. Zip Code 20874 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942- If Yes, Give Year or Dates: 1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fisheries Biologist | | | 16b. Kind of Business/Industry Government | |
| 17. Father's Name (First, Middle, Last) James C. Otis, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cecil Mignault | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James R. Otis, Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14613 Brookmead Drive, Germantown, MD 20874 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Webster Church Cemetery | | Date Nov. 26 1999 | | 20c. Location - City or Town, State Webster Twp., Michigan | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIORGAN SYSTEM FAILURE Due to (or as a consequence of): b. SEPTIC SHOCK Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 9 DAYS 9 DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Anemia Thrombocytopenia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  SHIVENDRA K. SAXENA | | | | 29c. License number D 30112 | | 29d. Date signed (Month, Day, Year) NOV 22 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIRENDRA K. SAXENA, MD 7100 DEER CROSSING COURT, BETHESDA MD 20817 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38204

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George E. Potter

2. Date of Death
Month Day Year
November 20, 19993. Time of Death
1:35P.

4a. Facility Name (If not institution, give street and number)

3000 Chapel View Drive

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

217-44-2882

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 8, 1911

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3000 Chapel View Drive

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1943-194613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sound Technician

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Louis Henry Potter

18. Mother's Name (First, Middle, Maiden Surname)

Grace Sullivan

19a. Informant's Name/Relationship (Type, Print)

Lorraine E. Sakaris (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9137 Falls Chapel Way Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery 11/24/1999

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate
Interval Between
Onset and DeathLess Than
24 hoursSequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Aortic Stenosis
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas M. Annulis, M.D.

29c. License number

D0052401

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Annulis, M.D. 11120 New Hampshire Avenue, #305 Silver Spring, Maryland 20904

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Benita G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-342-1000.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38205

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE EDWIN PONTIOUS, SR.

2. Date of Death

Month Day Year
NOVEMBER 19, 1999

3. Time of Death

1:10 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1107 McNEIL LANE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

579-01-3477

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAR. 21, 1918

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

VIRGINIA

10b. County

FAIRFAX

10c. City, Town or Location

LORTON

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7945 TIMARANO COURT

10f. Zip Code

22079

10g. Citizen of What Country?

UNITED STATES
OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1945-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify:
WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

GENERAL CONTRACTOR/
BUS DRIVER

16b. Kind of Business/Industry

STATES OF
MARYLAND AND VIRGINIA

17. Father's Name (First, Middle, Last)

FRED G. PONTIOUS

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA MAE FORD

19a. Informant's Name/Relationship (Type, Print)

GEORGE E. PONTIOUS, JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1109 McNEIL LANE SILVER SPRING, MARYLAND 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

NATIONAL MEMORIAL PARK

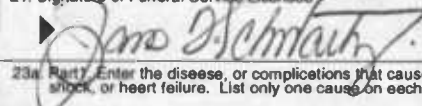
Date

NOV. 23,
1999

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIRE AVENUE
SILVER SPRING, MARYLAND 20904-2891

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

DAUGHTER'S RESIDENCE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D35635

29d. Date signed (Month, Day, Year)

NOVEMBER 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH KAPLAN, M.D., 18111 PRINCE PHILLIP DRIVE, OLNEY MARYLAND 20832

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38206

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Ella Pier

2. Date of Death

November 20, 1999

3. Time of Death

7:05 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-44-7877

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Jan 6, 1935

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2716 Munson Street

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jester C. McDonald

18. Mother's Name (First, Middle, Maiden Surname)

Anna E. King

19a. Informant's Name/Relationship (Type, Print)

Edward Pier / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2716 Munson Street, Wheaton, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Nov 24
1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Robert E Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. Metastatic Small Cell Lung Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frederick G. Barr M.D.

29c. License number

D22775

29d. Date signed (Month, Day, Year)

November 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr, M.D. 2101 Medical Park Dr., #210, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38207

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|--|---|---------------------------|---|---|--|---|--|--|--|--|--|-------------------------------|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) IDA L. PENN | | | | 2. Date of Death Month Day Year 11 22 99 | | | | 3. Time of Death 3:05AM | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death OLNEY | | | | 4c. County of Death MONTGOMERY | | | | | | | | |
| Funeral Director | 5. Social Security Number 142-22-8372 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 98 Yrs. | | 8. Date of Birth (Month, Day, Year) 3/17/1901 | | 9. Birthplace (State or Foreign Country) LATVIA | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 10e. Street and Number 14400 HOMECREST ROAD | | | | 10f. Zip Code 20906 | | | | 10g. Citizen of What Country? USA | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | | 16b. Kind of Business/Industry OWN HOME | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) HEIMAN ISAAC LOWENSTEIN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN KAHN | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) SAUL L. PENN/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10303 ROSSMORE COURT, BETHESDA, MARYLAND 20814 | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. LEBANON | | | | Data 11/24/99 | | 20c. Location - City or Town, State ISELIN, NEW JERSEY | | | | | | | |
| 21. Signature of Funeral Service Licensee Donald C. Stottmeyer | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate interval Between Onset and Death IMMEDIATE | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FECAL OBSTIPATION RIGHT VENTRICULAR CONGESTIVE HEART FAILURE | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier Philip G. Henjum, M.D. | | 29c. License number D35045 | | 29d. Date signed (Month, Day, Year) NOVEMBER 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP G. HENJUM, M.D. 3416 OLANDWOOD COURT #204, OLNEY, MARYLAND 20832 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature B. Spahr | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38208

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GEORGE PAPAIOANNOU

2. Date of Death

Month Day Year
NOV. 22, 1999

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

001-42-3944

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4/23/33

9. Birthplace (State or Foreign Country)

GREECE

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8018 THORNLEY COURT

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

BISHOP GREEK ORTHODOX CHURCH RELIGION

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

VASILI PAPAIOANNOU

18. Mother's Name (First, Middle, Maiden Surname)

ALEXANDRA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

ELENI SPIROU - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

252 PARK STREET, MORGANTOWN, W.VA. 26505

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEM. 11/27/99 SILVER SPRING, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility JOSEPH GAWLER'S SONS

5130 WISC. AVE. WASH. D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. INTRACRANIAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 46355

29d. Date signed (Month, Day, Year)

11/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAHESH JAITLEY, MD. 121 CONGRESSIONAL LANE # 409 ROCKVILLE, MD. 20852

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38209

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAURICE T PHILLIPS

2. Date of Death
Month Day Year

NOVEMBER 22 1999

3. Time of Death

11:23AM

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

215-26-5816

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

April 4, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

711 Seventh St., P.O. Box 13

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Postmaster

16b. Kind of Business/Industry

Government Service

17. Father's Name (First, Middle, Last)

Raymond L. Phillips

18. Mother's Name (First, Middle, Maiden Summa)

Marcie Jones

19a. Informant's Name/Relationship (Type, Print)

Freda Phillips/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 13, Pocomoke City, MD 21851

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

First Baptist Cemetery

Date

11/26/99

20c. Location - City or Town, State

Pocomoke City, MD

21. Signature of Funeral Service Licensee

Michael Dean MO1129

22. Name and Address of Facility

Holloway-Melson Funeral Home Professional Assoc.
103 Linden Ave., Pocomoke City, MD 2185123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ISCHEMIC CARDIOMYOPATHY

Approximate
Interval Between
Onset and Death

TWO YEARS

Due to (or as a consequence of):

b. SEVERE COPD

THREE YEARS

Due to (or as a consequence of):

c. RENAL FAILURE

FIVE YEARS

Due to (or as a consequence of):

d. TYPE II DIABETES MELLITUS

ONE YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

AORTIC VALVE REPLACEMENT

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael Dean attending physician

29c. License number

D0046029

29d. Date signed (Month, Day, Year)

NOVEMBER 22 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL K. GARUBA, MD. 12137 ELM STREET, PRINCESS ANNE, MD 21853

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Barbara S. Spauld

841

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38210

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | | | | |
|---|---|---|--|---|--|---|--|--|--|---|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Ruth Thomas Rutherford | | | | | | 2. Date of Death Month Day Year November 19 1999 | | 3. Time of Death 12:10PM | | | | | | | |
| 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | | | | | | |
| 5. Social Security Number 214-03-8269 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 15, 1914 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Kensington | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 3118 Jennings Road | | | | 10f. Zip Code 20895 | | 10g. Citizen of What Country? USA | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | | 16b. Kind of Business/Industry Bell Laundry | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Andrew Jessup Thomas | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie May Howard | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Martha E. Rutherford (daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3118 Jennings Road Kensington, Maryland 20895 | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park | | 20c. Date 11/23/99 | | 20d. Location - City or Town, State Rockville, Maryland | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Respiratory Failure Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 hour</td> </tr> <tr> <td>b. Pneumonia Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Respiratory Failure Due to (or as a consequence of): | Approximate Interval Between Onset and Death 1 hour | b. Pneumonia Due to (or as a consequence of): | c. _____ Due to (or as a consequence of): | d. _____ Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Respiratory Failure Due to (or as a consequence of): | Approximate Interval Between Onset and Death 1 hour | | | | | | | | | | | | | |
| | b. Pneumonia Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | c. _____ Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | d. _____ Due to (or as a consequence of): | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Hypertension Arteriosclerotic Cardiovascular Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  Peter B. Shaver MD | | | | 29c. License number 021910 | | 29d. Date signed (Month, Day, Year) November 19, 1999 | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3921 Ferrara Dr. Wheaton, MD 20906 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38211

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna H. Rothe | | | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 11:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care of Potomac | | | | | | 4b. City, Town, or Location of Death Potomac | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 578-24-2272 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 10, 1910 | | 9. Birthplace (State or Foreign Country) Massachusetts | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Washington | | 10c. City, Town or Location Smithsburg | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 13502 Loy Wolfe Road | | | | 10f. Zip Code 21783 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary | | | 16b. Kind of Business/Industry Banking | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Michael Harpin | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Melina Bardier | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Warren Rothe (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13502 Loy Wolfe Rd. Smithsburg, Md. 21783 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date Nov. 24, 1999 | | 20c. Location - City or Town, State Silver Spring, Md. | | | |
| | 21. Signature of Funeral Service Licensee Curtis E. Day | | | | 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. congestive Heart Failure. Due to (or as a consequence of): b. Cerebral Vascular Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 2 days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Robert Krader MD | | | | 29c. License number 005937 | | | | 29d. Date signed (Month, Day, Year) November 22, 1999 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT KRADER, MD 10313 BEACON AVE S/1516 N/1 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

DNCE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38212

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WORLEY LEON ROBERTS

2. Date of Death

Month Day Year
NOVEMBER 21 1999

3. Time of Death

8:10 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

225-58-0037

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 27 1943

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8933 Watkins Road

10f. Zip Code

20882

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Office Building

17. Father's Name (First, Middle, Last)

Worley Bernice Roberts

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Cain

19a. Informant's Name/Relationship (Type, Print)

Dorothy A. Roberts / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8933 Watkins Road, Gaithersburg, Maryland 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenwood Cemetery

Date

11/26/99

20c. Location - City or Town, State

Coeburn, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, Maryland 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

ACUTE

SUB. ACUTE

CHRONIC

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

53177

29d. Date signed (Month, Day, Year)

November 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Wallmark, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-5055.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38213

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Artice Mary Remmert

2. Date of Death

November 18, 1999

3. Time of Death

4:56 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

540-20-3572

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 4, 1922

9. Birthplace (State or Foreign Country)

Oregon

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12028 Coldstream Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Montgomery County

Public Schools

17. Father's Name (First, Middle, Last)

William Arbuckle

18. Mother's Name (First, Middle, Maiden Surname)

Mary Viegas

19a. Informant's Name/Relationship (Type, Print)

David Remmert/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1702 Kirk Road, Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Nov. 19, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Will E. Brown M00672

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 West Montgomery Avenue,
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. congestive heart failure

Approximate
Interval Between
Onset and Death

one week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. acute myocardial infarction

one week

c. atrial fibrillation

one week

d. dilated cardiomyopathy

ten years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C. difficile enteritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

G. Peter Pushkas MD

29c. License number

D 21531

29d. Date signed (Month, Day, Year)

Nov. 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Peter Pushkas, M.D., 11510 Old Georgetown Road, Rockville, MD 20852-2736

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

G. Sparks

State
RegistrarArticle Remmert Act 023670797 exp 11/18/99 4:56p
JW

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
00252.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38214

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES ELEANOR RAY

2. Date of Death
Month Day Year
November 19, 19993. Time of Death
7:00 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

Potomac Valley Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

578-20-8435

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 20, 1918

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1235 Potomac Valley Road

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

John Adam Matheides

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Marie Dougherty

19a. Informant's Name/Relationship (Type, Print)

Doris M. Ray (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6001 Arlington Blvd. #604, Arlington, Va. 22044

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Prospect Hill Cemetery

Date

11/23/99 Washington, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Murphy Falls Church Funeral Home
1102 W. Broad St., Falls Church, Va.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Myocardial infarction

Due to (or as a consequence of):

gastrointestinal bleeding

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

acute

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

1 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D01120

29d. Date signed (Month, Day, Year)

22 NOVEMBER 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WALTER E. GOODE MD 1299 LAMARCTON DRIVE SILVER SPRING, MD 20902

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

THE [illegible] OF [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible] [illegible]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38215

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marga S. Rath | | | | 2. Date of Death Month November Day 20 , Year 1999 | | 3. Time of Death 6:39A. | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 053-12-3904 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 22, 1921 | 9. Birthplace (State or Foreign Country) Germany |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Greenbelt | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 22 Ridge Road | | | | 10f. Zip Code 20770 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | 16b. Kind of Business/Industry own home | |
| 17. Father's Name (First, Middle, Last) Adolf Thies | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gesine Neulmann | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sieglinde Hayes (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Empire Place Greenbelt, Maryland 20770 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | Date 11/24/1999 | | 20c. Location - City or Town, State Cheltenham, MD. |
| 21. Signature of Funeral Service Licensee Donald V. Borgwardt | | | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | Sudden |
| Due to (or as a consequence of): Congestive Heart Failure | | | | | | | | Years |
| Due to (or as a consequence of): Cor Pulmonale | | | | | | | | Years |
| Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease | | | | | | | | Years |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| Hypertension | | | | | | | | |
| Hypothyroidism | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier SK Gupta MD | | | | 29c. License number D32332 | | 29d. Date signed (Month, Day, Year) November 20, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SK Gupta, M.D. 9801 Georgia Avenue, #220 Silver Spring, Maryland 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

5

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38216

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Dennis Michael Riffin

2. Date of Death

November 16 1999

3. Time of Death

1405

4a. Facility Name (If not institution, give street and number)

Kent & Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

159-36-6386

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 16, 1945

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5571 Boundary Avenue

10f. Zip Code

21661

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

Ellwood V. Riffin

18. Mother's Name (First, Middle, Maiden Surname)

Ruth M. Thomas

19a. Informant's Name/Relationship (Type, Print)

Anna Mae Riffin/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5571 Boundary Avenue, Rock Hall, MD 21661

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sharon Hills Memorial Park

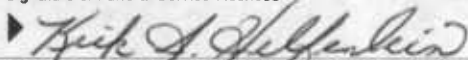
Date

11/20/99

20c. Location - City or Town, State

Dover, DE

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, MD 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 1 min.

> 5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TYPE 2 DIABETES

MORBID OBESITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

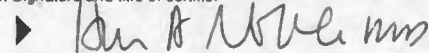
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 41587

29d. Date signed (Month, Day, Year)

11/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

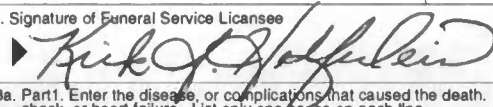
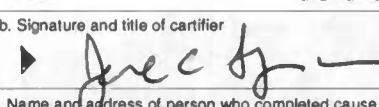
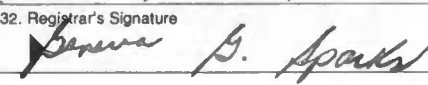
NOV 18 1955

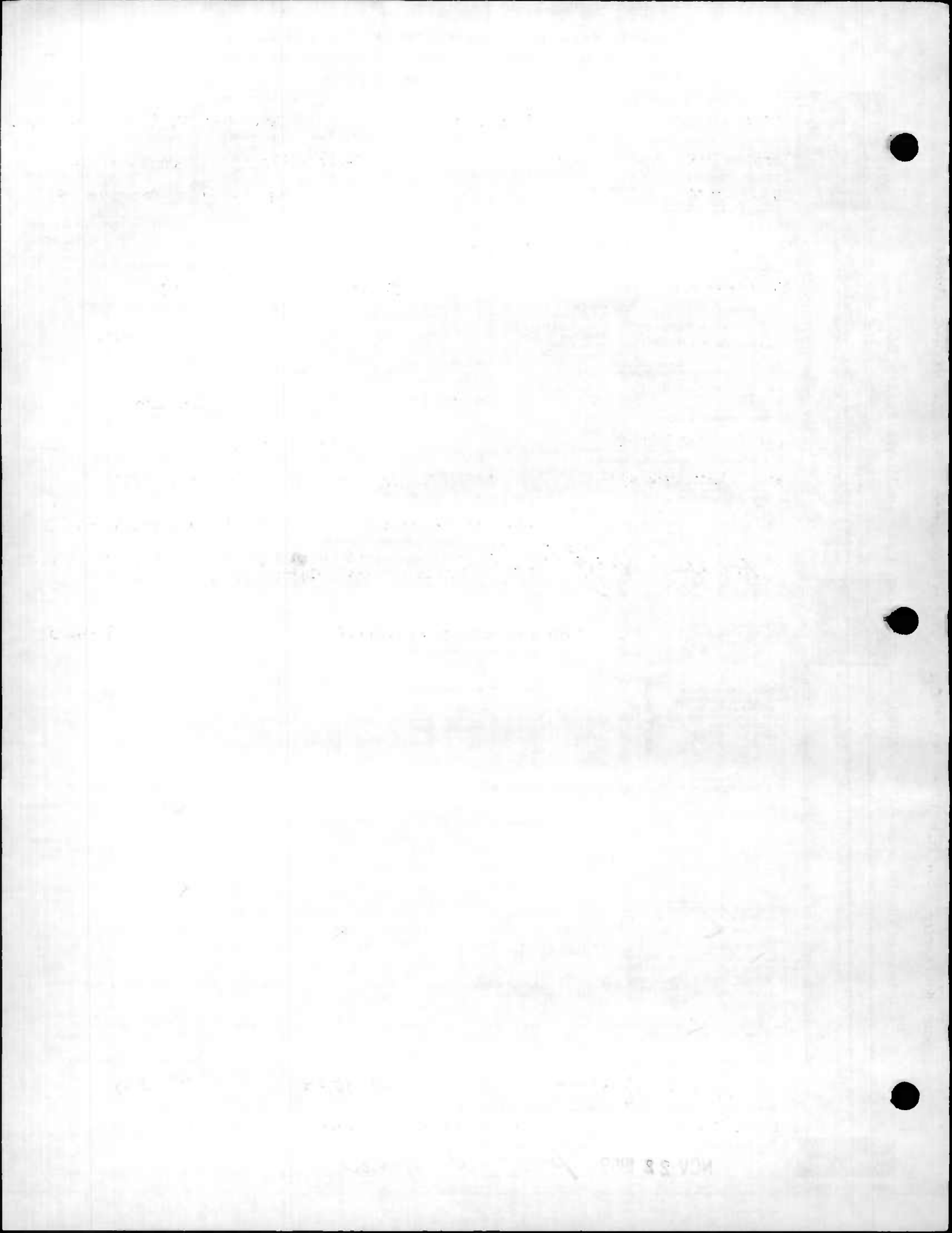
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38217

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|---|---------------------------------------|--|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jessie Connett Richards | | | | 2. Date of Death Month November Day 20 Year 1999 | | | | 3. Time of Death 6:40 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number) Corsica Hills Nursing Home | | | | 4b. City, Town, or Location of Death Centreville | | | | 4c. County of Death Queen Anne's | | |
| Funeral Director | 5. Social Security Number 151-03-2176 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) August 27, 1914 | | 9. Birthplace (State or Foreign Country) Paterson, NJ | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Queen Anne's | | 10c. City, Town or Location Chestertown | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 404 River View Road | | | | 10f. Zip Code 21620 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own home | | | |
| | 17. Father's Name (First, Middle, Last) Edward Elmer Connett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jessie Stewart | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Nancy Plummer/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12302 Tilbury Lane, Bowie, Maryland 20715 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery | | Date 11/24/99 | | 20c. Location - City or Town, State Chestertown, MD | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHAMBERLAIN Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 mcs | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 1213024 | | | 29d. Date signed (Month, Day, Year) 11-22-99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Seymour, 122 Speer Road, Suite 5, Chestertown, MD 21620 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | | | | |



SUSAN J. SULLIVAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART II, 27, 28A-F

PER MEO 6878 1-3-2000

Certificate of Death

Reg. No.

99 38218

| | | | | | | | | |
|--|---|--|---|--------------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Susan Jean Sullivan | | | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | 3. Time of Death 1013 AM | |
| | 4a. Facility Name (If not institution, give street and number) 308 TILGHMAN STREET | | | | 4b. City, Town, or Location of Death OXFORD | | 4c. County of Death TALBOT | |
| Funeral Director | 5. Social Security Number 217-42-4967 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 58 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 10, 1940 | | 9. Birthplace (State or Foreign Country) DC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Virginia | 10b. County N/A | 10c. City, Town or Location Alexandria | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 3601 Gunston Road | | | | 10f. Zip Code 22302 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management | | 16b. Kind of Business/Industry Government | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) James E. Sullivan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Meta T. Thran | | | |
| | 19a. Informant's Name/Relationship (Type, Print) James R. Sullivan / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Burnt Mills Avenue, Silver Spring, MD 20901 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Data Nov 22 1999 | | 20c. Location - City or Town, State Alexandria, VA | |
| | 21. Signature of Funeral Service Licensee <i>Andrew J. Cole</i> | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd W., Silver Spring, MD 20901 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ETHYLENE GLYCOL POISONING a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ALCOHOLISM | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) FOUND: 11-18-99 | | 28b. Time of Injury FOUND: 10:13 | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred SUBJECT DRANK ANTI-FREEZE | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN DRIVEWAY | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 308 TILGHMAN ST OXFORD, MARYLAND | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Dennis J. Chute, MD</i> | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | |
| State Registrar | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38219

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mae Sukon

2. Date of Death
Month Day Year

November 21, 1999

3. Time of Death

11:59 am

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

052-10-1261

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 18, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

DC

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3205 Stephenson Place, N.W.

10f. Zip Code

20015

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Data Processor

16b. Kind of Business/Industry

New York

State Department

17. Father's Name (First, Middle, Last)

William Dunayer

18. Mother's Name (First, Middle, Maiden Surname)

Celia Tannenbaum

19a. Informant's Name/Relationship (Type, Print)

Celia Dunayer/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3205 Stephenson Place, N.W., Washington, DC 20015

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Beth/David Cemetery

Date

Nov 23

1999

20c. Location - City or Town, State

Elmont, New York

21. Signature of Funeral Service Licensee

Tracy A. Shiver

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myasthenia Gravis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Lillie MD

29c. License number

D53244

29d. Date signed (Month, Day, Year)

November 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katharine R. Lillie, MD 11140 Rockville Pike #348, Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38220

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | |
|--|--|---|---|--|--------------------------------|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JAMES CRAIG STEWART | | | | | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | 3. Time of Death 1034 AM | | | |
| 4a. Facility Name (If not institution, give street and number) 90 WAVERLY DRIVE | | | | | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | | | |
| 5. Social Security Number 367 70 1894 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 42 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT. 11, 1957 | | 9. Birthplace (State or Foreign Country) WASHINGTON | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MD. | | 10b. County FREDERICK | | 10c. City, Town or Location FREDERICK | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 90 WAVERLY DRIVE | | | | 10f. Zip Code 21702 | | 10g. Citizen of What Country? UNITED STATES | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICAL ENGINEER | | | 16b. Kind of Business/Industry N.R.C U.S. GOVERNMENT | | | | |
| 17. Father's Name (First, Middle, Last) JAMES COLIN STEWART | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARJORIE ANN HARLAND | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) KAREN E. T. STEWART, WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2746 LOCH HAVEN DR., IJAMSVILLE, MD. 21754 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY | | Date 11/20/99 | | 20c. Location - City or Town, State ALEXANDRIA, VA. | | | | | |
| 21. Signature of Funeral Service Licensee Muriel H. Barber | | | | 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of the Liver Due to (or as a consequence of): b. Chronic Alcoholism Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier J. Aaron Locke, MD | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

[Faint, illegible handwritten text covering the majority of the page]

[Handwritten signature]

[Faint handwritten text below the signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38221

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETTA STERN

2. Date of Death

Month Day Year
11.20.99

3. Time of Death

10:41 AM

4a. Facility Name (If not institution, give street and number)

6685 MINK HOLLOW ROAD

4b. City, Town, or Location of Death

HIGHLAND

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

065.03.5419

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09.14.1917

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14600 DEER HURST TERRACE

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL SILVERBERG

18. Mother's Name (First, Middle, Maiden Surname)

SADIE SCHACHTER

19a. Informant's Name/Relationship (Type, Print)

ABRAHAM STERN /HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14600 DEER HURST TERRACE, SILVER SPRING, MD 20906

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW MONTEFIORE CEMETERY

Date

11.22.99

20c. Location - City or Town, State

PINELAWN, L.I., N.Y.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

METASTATIC BREAST CANCER

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify)

SON'S HOME

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DL5947

29d. Date signed (Month, Day, Year)

NOVEMBER 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD SAGEL, 5540 TEN OAKS RD, CATAPLACE, MD 21049

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38222

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Clarence Stargel, Jr. | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 1:50 PM | |
| | 4a. Facility Name (If not institution, give street and number) Montgomery Village Care & Rehab. Center | | | | 4b. City, Town, or Location of Death Montgomery Village | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 256-42-1664 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | 8. Date of Birth (Month, Day, Year) Jun 21, 1926 | 9. Birthplace (State or Foreign Country) Georgia | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Frederick | |
| 10c. City, Town or Location Mt. Airy | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 307 Westridge Circle | | | | 10f. Zip Code 21771 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Technician | | 16b. Kind of Business/Industry Grocery | | |
| 17. Father's Name (First, Middle, Last) John Clarence Stargel, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eunice Jackson | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James C. Stargel, son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Westridge Circle, Mt. Airy, MD 21771 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | Date Nov 22, 1999 | | 20c. Location - City or Town, State Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Adenocarcinoma</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D42518 | | 29d. Date signed (Month, Day, Year) November 22, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, M.D., 11119 Rockville Pike, #316 Rockville, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38223

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry N. Siebenberg

2. Date of Death

November 19, 1999

3. Time of Death

4:10 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

217-34-4594

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 24, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13525 Collingwood Tr.

10f. Zip Code

20904

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Armed Forces? ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

William Siebenberg

18. Mother's Name (First, Middle, Maiden Surname)

Ida Sugam

19a. Informant's Name/Relationship (Type, Print)

Judy Siebenberg/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13525 Collingwood Tr. Silver Spring, MD. 20904

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens

Date

11/23

20c. Location - City or Town, State

Olney, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stein Hebrew Memorial Funeral H.

232 Carroll St. NW. Washington, DC. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatitis

Due to (or as a consequence of):

b. Cancer of the head of Pancreas

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Chahar Dhamkheh MD

29c. License number

D43496

29d. Date signed (Month, Day, Year)

11-20-99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad A. Khakid mb 8630 Penton Street Silver Spring MD 20910

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

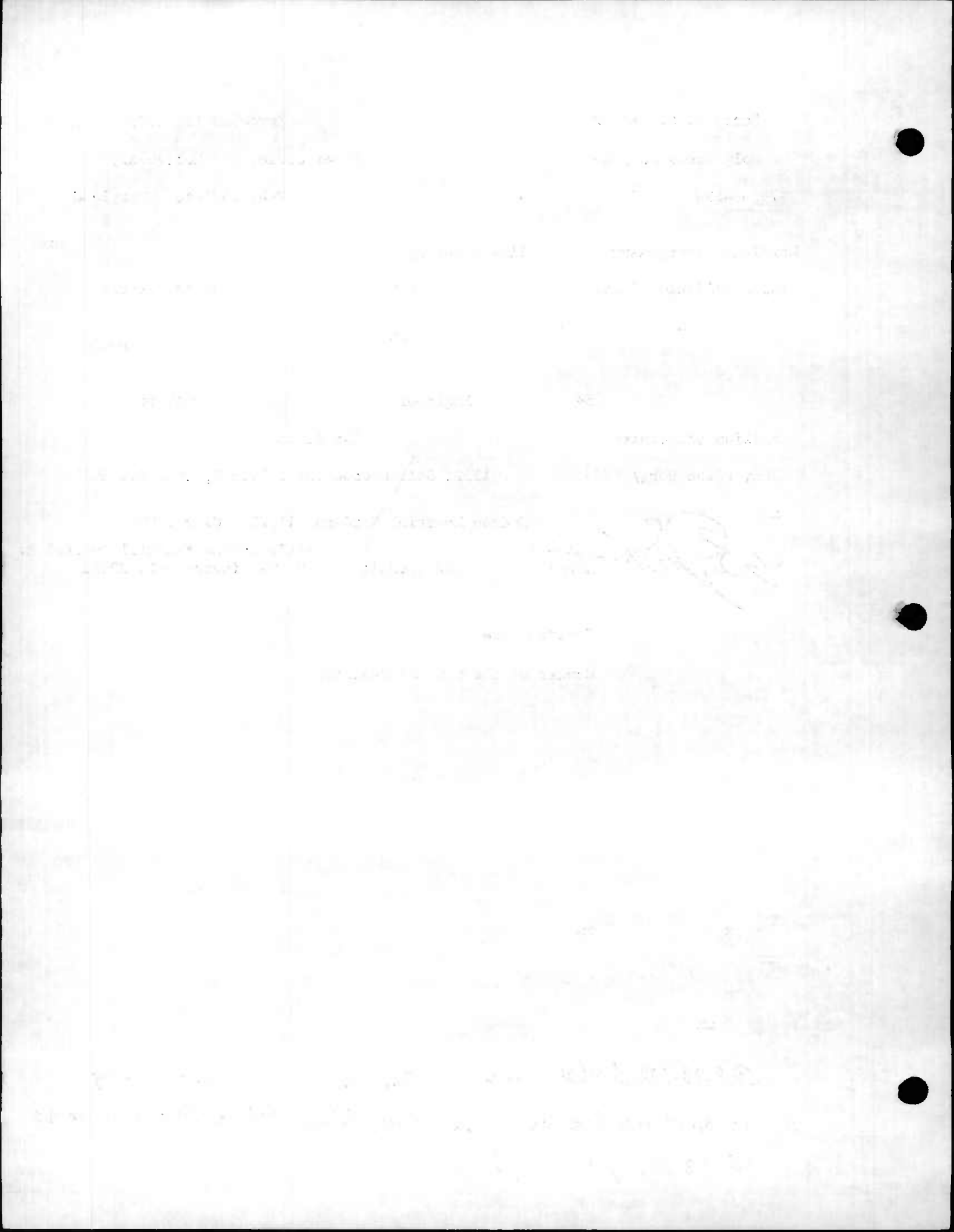
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38224

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph William Sharkey

2. Date of Death
Month Day Year
November 19, 19993. Time of Death
10:50amFuneral
Director

4a. Facility Name (If not institution, give street and number)

19310 Clubhouse Road #311A

4b. City, Town, or Location of Death

Montgomery Village Montgomery

4c. County of Death

5. Social Security Number

107-10-5387

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 13, 1912

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19310 Clubhouse Road #311A

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Service Manager

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Thomas Sharkey

18. Mother's Name (First, Middle, Maiden Surname)

Mary Dehring

19a. Informant's Name/Relationship (Type, Print)

Maryann Sharp (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13113 Scarlet Oak Drive, Darnestown, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Nov 20, 1999

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY CONGESTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEKS

b. BRONCHITIS

Due to (or as a consequence of):

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

DIS017

29d. Date signed (Month, Day, Year)

November 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALFRED MULLER 1396 PICCARD DRIVE, ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38225

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CAROL BAUER SHATTUCK

2. Date of Death

Month Day Year
NOV 19 1999

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

220-28-6872

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 1, 1932

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12109 Little Creek Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Music Teacher

16b. Kind of Business/Industry

Montgomery County
Public Schools

17. Father's Name (First, Middle, Last)

Charles

Bauer

18. Mother's Name (First, Middle, Maiden Summa)

Mary Ryber

19a. Informant's Name/Relationship (Type, Print)

A.B. Shattuck (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12109 Little Creek Dr., Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

11/22/99

20c. Location - City or Town, State

Beltsville,
Maryland

21. Signature of Funeral Service Licensee

M00956

22. Name and Address of Facility Rapp Funeral & Cremation Services,

Stephen D. Lohrmann, P.A.
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

A.S. Ramage

D.O.

29c. License number

0062 (SC)

29d. Date signed (Month, Day, Year)

11/19/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A.S. RAMAGE, MAJ, MC, USA

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State
Registrar

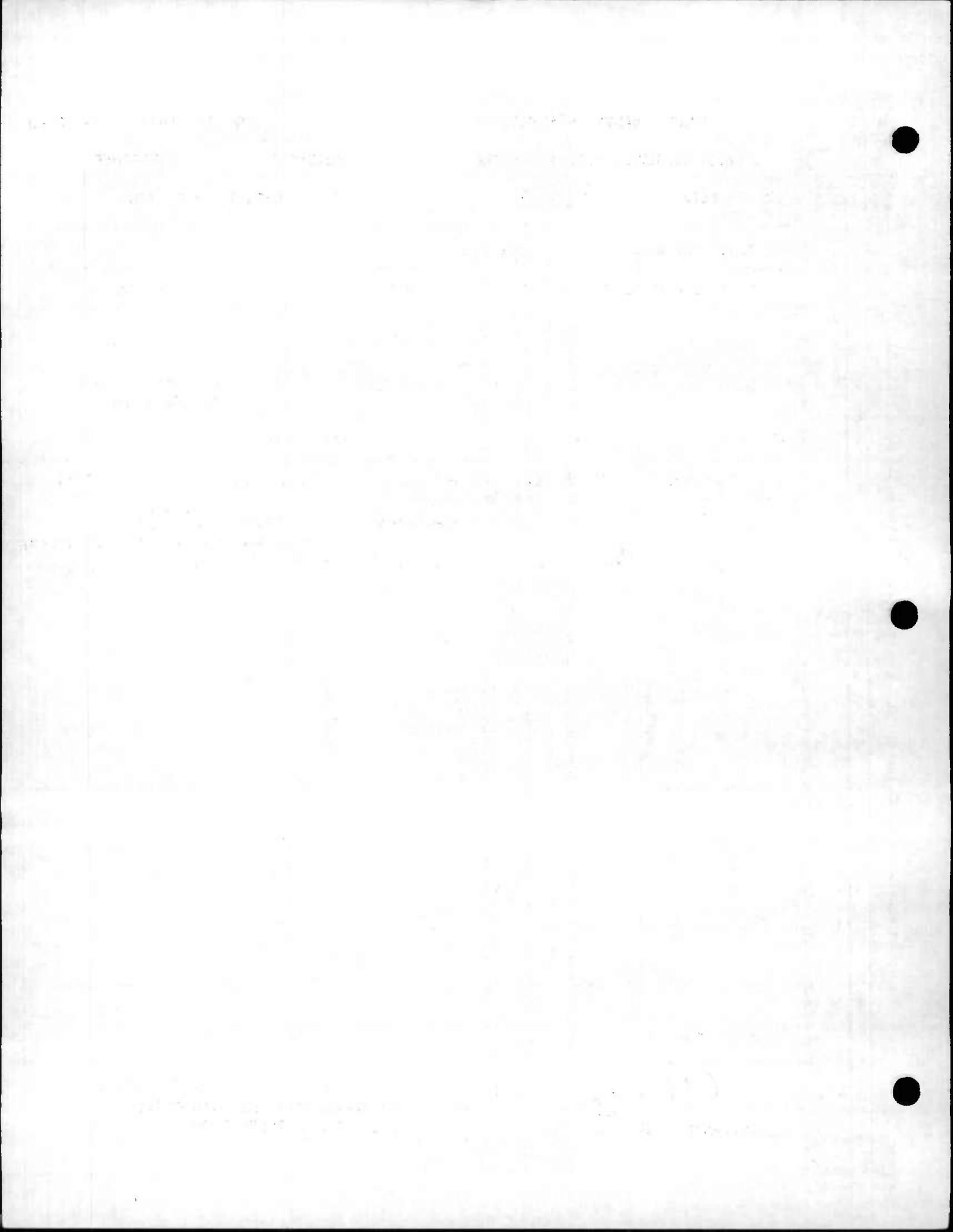
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38226

Amend #20b, 11/30/99, JW, Montg. County Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kathryn Agnes Shannon | | | | | 2. Date of Death Month Day Year November 21, 1999 | | 3. Time of Death 11:00 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) 10114 Ashburton Lane | | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 121-12-4548 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) May 17, 1918 | | 9. Birthplace (State or Foreign Country) New York | | |
| | Usual Residence of Decedent | | | | | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Montgomery | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? United States | | | | |
| | 10e. Street and Number 10114 Ashburton Lane | | | | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent | | 16b. Kind of Business/Industry Insurance | | | | |
| | 17. Father's Name (First, Middle, Last) Lawrence Shannon | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna McDermott | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Rita Conroy/Sister | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10114 Ashburton Lane, Bethesda, Maryland 20817 | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery | | Date November 26, 1999 | | 20c. Location - City or Town, State Canandaigua, New York | | | |
| | 21. Signature of Funeral Service Licensee <i>Michael E. Higgins</i> M00846 | | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardiorespiratory Failure Due to (or as a consequence of): b. Parkinson's Disease Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>M. Bhaskar Rao</i> | | | | | 29c. License number MD 44 249 | | | 29d. Date signed (Month, Day, Year) 11/22/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Bhaskar Rao, M.D., 5630 Shields Drive, Bethesda, Maryland 20817 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | 32. Registrar's Signature <i>Benita B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

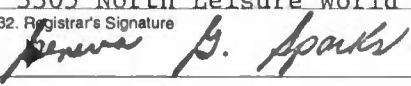
State of Maryland / Department of Health and Mental Hygiene

99 38227

Amend #5, 11/24/99, BW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marian H. Seltzer | | | | 2. Date of Death Month November Day 20 Year 1999 | | 3. Time of Death 8:20 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Bedford Court Nursing Home | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 216-40-8134 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 1, 1917 | | |
| | 9. Birthplace (State or Foreign Country) Iowa | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 15311 Beaverbrook Court #3J | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Para Legal | | 16b. Kind of Business/Industry Law | | | | | |
| 17. Father's Name (First, Middle, Last) Francis Marion Harlan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Hertert | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marilyn Lynt (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Union Street N., Marshfield, Massachusetts 02059 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Date 11/22/99 | | 20d. Location - City or Town, State Alexandria, Virginia | | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Lung Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 5 years | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gangrene of Leg Peripheral Vascular Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D 24543 | | 29d. Date signed (Month, Day, Year) November 20, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, M.D. 3305 North Leisure World Blvd. Silver Spring, Maryland 20906 | | 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38228

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert A. Sauer

2. Date of Death

November 23, 1999

3. Time of Death

12:35AM

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

215-44-8160

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 29, 1900

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4909 Battery Lane, #3

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Stephen Sauer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Theresa Kluber

19a. Informant's Name/Relationship (Type, Print)

Robert W. Sauer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14533 Antigone Drive, Gaithersburg, Maryland 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Nov 27

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

 M0084622. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin
Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 Months

b. Urosepsis

Due to (or as a consequence of):

1 Month

c. Aspiration Pneumonia

Due to (or as a consequence of):

1 Month

d. Atherosclerotic Vascular Disease

Approx.
6 MonthsSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D35996

29d. Date signed (Month, Day, Year)

November 23, 1999


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, M.D. 2101 Medical Park Drive, #210, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38229

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Arthur Russell Sellers

2. Date of Death

November 18, 1999

3. Time of Death

11:28 AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

500-05-4142

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 10, 1919

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5728 Crawford Drive

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Roy Sellers

18. Mother's Name (First, Middle, Maiden Surname)

Helen Marie Shelton

19a. Informant's Name/Relationship (Type, Print)

Mary Louise Sellers/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5728 Crawford Drive, Rockville, MD 20851-1808

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

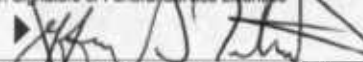
Date

Nov. 22, 1999

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

 M00689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death:

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D24942

29d. Date signed (Month, Day, Year)

Nov 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD

31. Date filed (Month, Day, Year)

NOV 22 1999

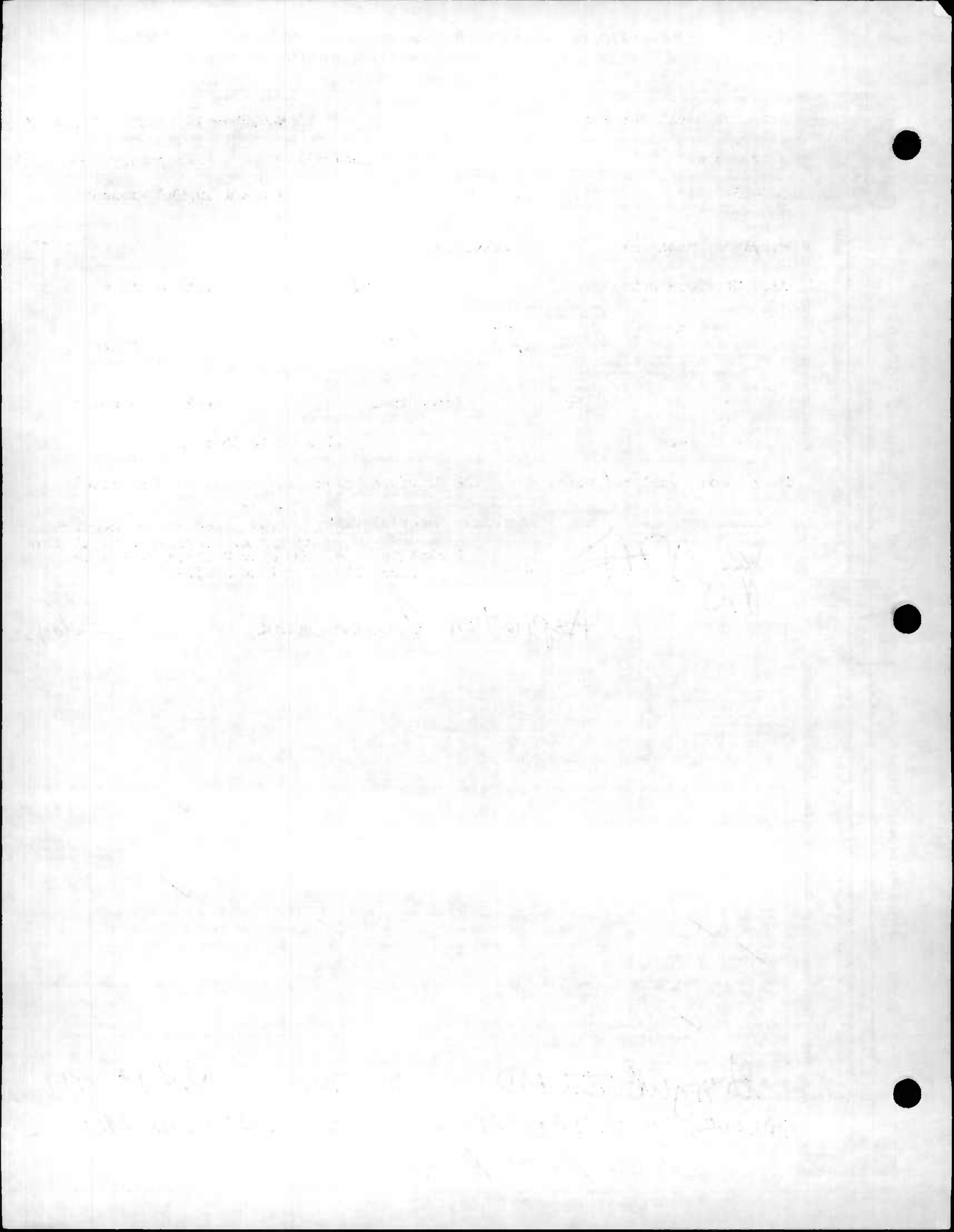
32. Registrar's Signature



State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38230

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas K. Saffos

2. Date of Death
Month Day Year

November 21, 1999

3. Time of Death

7:55 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare- Layhill Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

238-40-1417

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 10, 1905

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18229 Queen Elizabeth Drive

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Konstantine Demetri Saffos

18. Mother's Name (First, Middle, Maiden Surname)

Argiro Vassilaras

19a. Informant's Name/Relationship (Type, Print)

Terry L. Stayeas / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18229 Queen Elizabeth Drive, Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

Nov 24

1999

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

10 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier

(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09577

29d. Date signed (Month, Day, Year)

11-22-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard H. Pollen, M.D. 10400 Connecticut Ave, Ste 606, Kensington, MD 20895

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38231

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) MARY LOLA STORY | | | | 2. Date of Death Month Day Year NOVEMBER 16 1999 | | 3. Time of Death 1928 | |
| 4a. Facility Name (If not institution, give street and number) KENT QUEEN ANNES HOSPITAL | | | | 4b. City, Town, or Location of Death CHESTERTOWN | | 4c. County of Death KENT | |
| 5. Social Security Number 216-40-4836 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) October 24, 1908 | |
| 9. Birthplace (State or Foreign Country) Goldsboro, MD | | 10a. State Maryland | | 10b. County Queen Anne's | | 10c. City, Town or Location Barclay | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 1309 Goldsboro Road | | 10f. Zip Code 21607 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own home | | | |
| 17. Father's Name (First, Middle, Last) William Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Anna Jackson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Louis Sudler Story, Jr./Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 25, Barclay, MD 21607 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sudlersville Cemetery | | Date 11/21/99 | | 20c. Location - City or Town, State Sudlersville, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Small bowel obstruction Due to (or as a consequence of):</p> <p>b. Dehydration Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 25%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>6 day</p> <p>6 day</p> </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  MD | | 29c. License number D51735 | | 29d. Date signed (Month, Day, Year) 11/17/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Delboy, MD, 6602 Church Hill Road, Chestertown, Maryland 21620 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 18 1999 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

PAGE 10

RECEIVED

NOV 1964

[Handwritten signature]

[Handwritten signature] NOV 19 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38232

| | | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|---|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mabel Comegys Sullivan | | | | | | 2. Date of Death Month Day Year November 2, 1999 | | 3. Time of Death 6:15 PM | |
| | 4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | | | | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 218-38-8240 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 6, 1912 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | 10a. State Md. | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 4016 Union Church Road | | | | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher | | | | 16b. Kind of Business/Industry Board of Education (Kent Co.) | | |
| 17. Father's Name (First, Middle, Last) Paul R. Comegys | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel Spear | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mabel Sullivan Esh Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 Union Church Rd., Salisbury, Md. 21801 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center | | | | 20c. Location - City or Town, State Stevensville, Md. | | |
| 21. Signature of Funeral Service Licensee JOHN R. MERCERON | | | | 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St., Millington, Md. | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. chronic obstructive pulmonary disease Due to (or as a consequence of): b. emphysema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 9-17 | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | | | 29c. License number 029349 | | 29d. Date signed (Month, Day, Year) 11/3/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 12 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

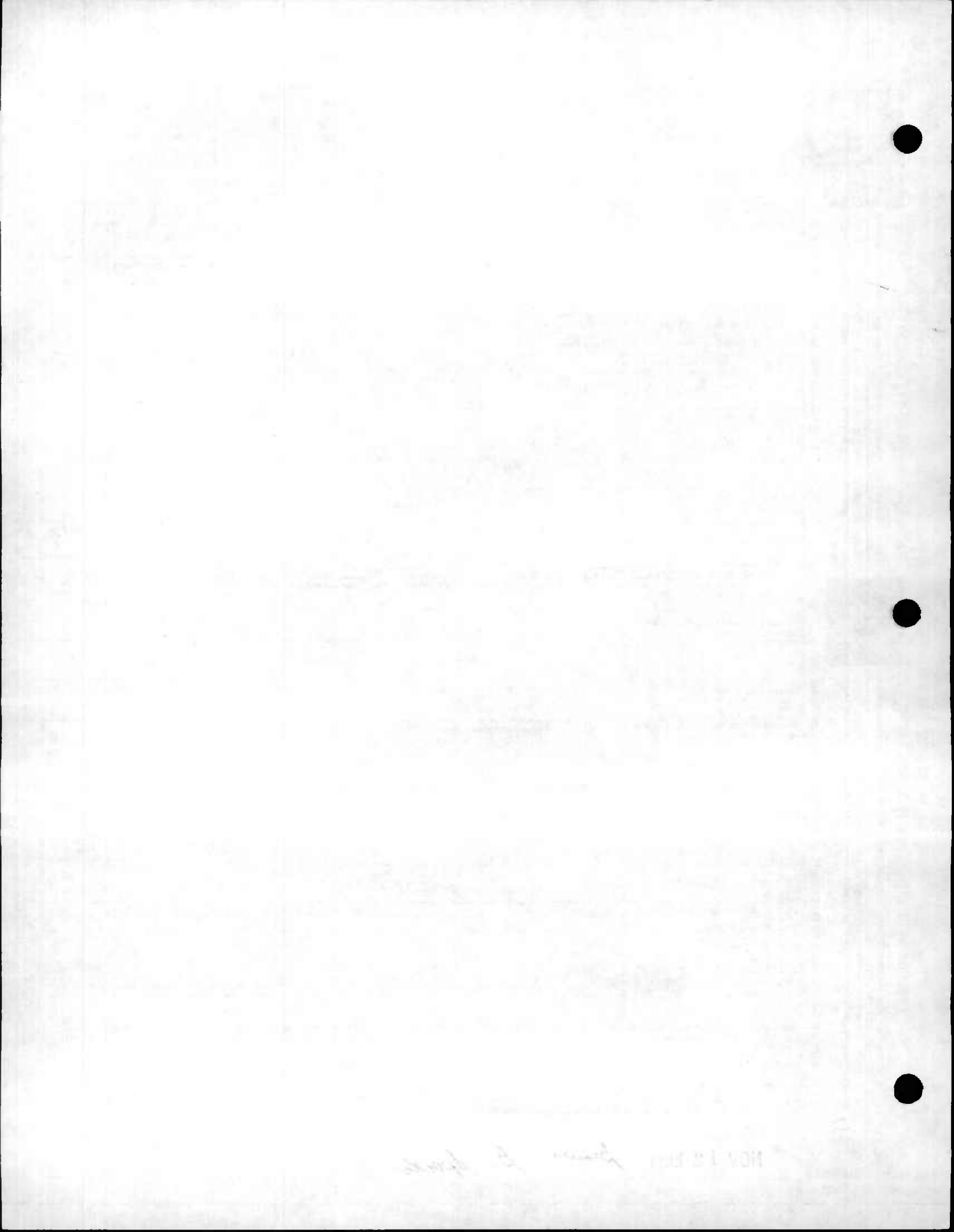
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar



per/ME, E.T, WCHD

State of Maryland / Department of Health and Mental Hygiene

99 38233

Amended Item #27, 28A thru 28f, 11/24/99 *Certificate of Death*

Reg. No.

1. Decedent's Name (First, Middle, Last) Stanley Smith

2. Date of Death Month NOVEMBER Day 12 Year 1999

3. Time of Death 1750

4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death BERLIN

4c. County of Death WORCESTER

5. Social Security Number 263-40-4971

6. Sex 1 M 2 F X

7. Age (In yrs. last birthday) 78

8. Date of Birth (Month, Day, Year) 10/22/1921

9. Birthplace (State or Foreign Country) West Virginia

10a. State MD

10b. County Worcester

10c. City, Town or Location Ocean City

10d. Inside City Limits 1 Yes 2 No X

10e. Street and Number 12309 Greenridge Lane Road

10f. Zip Code 21842

10g. Citizen of What Country? USA

11. Marital Status 1 Navar Married 2 Married X 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No X

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No X Specify: White

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) Waterman

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seafood Industry

17. Father's Name (First, Middle, Last) Joseph Smith

18. Mother's Name (First, Middle, Maiden Surname) Anela Stalmack

19a. Informant's Name/Relationship (Type, Print) Lottie Jean Smith - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12309 Greenridge Land RD, Ocean City, MD 21842

20a. Method of Disposition 1 Burial 2 Cremation X 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crematory

20c. Date 11/14/99

20d. Location - City or Town, State Frankford, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility The Burbage Funeral 108 Williams Street, Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Subdural Hematoma Head Injuries

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No X 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes X 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes X 2 No

25. Was case referred to medical examiner? 1 Yes X 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient X 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident X 3 Suicida 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 11/11/99

28b. Time of Injury 8:30 PM

28c. Injury at Work? 1 Yes X 2 No

28d. Describe how injury occurred subject fell to ground

28e. Location (Street and Number or Rural Route Number, City or Town, State) South Harbor Rd. Ocean City, MD

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Dennis J. Chute, MD

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) NOVEMBER 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10/H Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) NOV 24 1999

32. Registrar's Signature

DMMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38234

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------|---|--|--|--------------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lemuel L. Turner | | | | 2. Date of Death Month Day Year November 20, 1999 | | | | 3. Time of Death 7:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) Fox Chase Rehabilitation & Nursing Center | | | | 4b. City, Town, or Location of Death Silver Spring | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 578-20-3455 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 4, 1919 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State N/A | | 10b. County N/A | | 10c. City, Town or Location Washington, D.C. | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 608 Jefferson Strret N.E. | | | | 10f. Zip Code 20011 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouseman | | | | 16b. Kind of Business/Industry U.S. Government | | |
| 17. Father's Name (First, Middle, Last) Lawrence Turner | | | | | 18. Mother's Name (First, Middle, Maiden Sumame) Alice Bell | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rose H. Turner, wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Jefferson St. N.E., Washington, D.C. 20011 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | | Date 11/26/99 | | 20c. Location - City or Town, State Brentwood, Maryland | | |
| 21. Signature of Funeral Service Director  | | | | | 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARDIOPULMONARY ARREST Due to (or as a consequence of): b. MULTI-ORGAN FAILURE Due to (or as a consequence of): c. MYELODYSPLASTIC SYNDROME Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death 1 WEEK 6 MONTHS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospitel: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier  | | | 29c. License number D52264 | | 29d. Date signed (Month, Day, Year) 11-26-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLEN R. SEGAL MD. 1299 LAMBERTON DR., SILVER SPRING, MD 20902 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 26 1999 | | | 32. Registrar's Signature  | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-552-8058.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial/Transit permit.

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38235

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) ALICIA CANDIDO URBINA | | | | 2. Date of Death Month NOVEMBER Day 18 Year 1999 | | 3. Time of Death 3:15 PM | |
| 4a. Facility Name (If not Institution, give street and number) 62 ORCHARD DRIVE | | | | 4b. City, Town, or Location of Death GAITHERSBURG | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number None | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 5, 1930 | |
| 9. Birthplace (State or Foreign Country) El Salvador | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 62 Orchard Drive | | | | 10f. Zip Code 20878 | | 10g. Citizen of What Country? El Salvador | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: El Salvadoran | | 14. Race - American Indian, Black, White, etc. Specify: Hispanic | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Julian Candido | | | | 18. Mother's Name (First, Middle, Maiden Surname) Josefina Urbina | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maria Sosa (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Orchard Drive Gaithersburg, Md. 20878 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chalatenago Cemetery | | Date Nov. 26, 1999 | | 20c. Location - City or Town, State Chalatenago, El Salvador | |
| 21. Signature of Funeral Service Licensee <i>Curtis E. Day</i> | | | | 22. Name and Address of Facility Devol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Compestive Heart Failure Due to (or as a consequence of): b. Ischaemic Cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death 1 month 2 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Adult onset Diabetes mellitus Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Amenudunello</i> | | | | 29c. License number D38262 | | 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr A. Mendhiratta 2401 Research Blvd Rockville MD 20850 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON

1914

OFFICE OF THE CHIEF OF BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

REPORT OF THE CHIEF OF BUREAU OF PLANT INDUSTRY

1914

FOR THE YEAR ENDING DECEMBER 31, 1914

BY

JOHN H. COOPER

CHIEF OF BUREAU

WASHINGTON: GOVERNMENT PRINTING OFFICE: 1915

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38236

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hui-Sheng Wu

2. Date of Death

November 21, 1999

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-86-2436

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec 4, 1935

9. Birthplace (State or Foreign Country)

Taiwan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14608 Pebblewood Dr

10f. Zip Code

20878

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Ching-Yeh Lin Wu/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14608 Pebblewood Dr, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

Nov 26

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

▶ Alan J. Daniels

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEPATOCELLULAR CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ [Signature]

29c. License number

D35635

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kneen 18111 Prince Philip Dr Oursay, MD 20852

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38237

| | | | | | | | | | |
|---|--|--|---|--------------------------------|---|--|--|---|-----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FORREST WOOD | | | | 2. Date of Death Month Day Year NOV. 23, 1999 | | 3. Time of Death 8:40 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 18326 Brooke Road | | | | 4b. City, Town, or Location of Death Sandy Spring | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 220-28-4260 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 19, 1930 | | 9. Birthplace (State or Foreign Country) S. Carolina | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Montgomery | 10c. City, Town or Location Sandy Spring | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 18326 Brooke Road | | | 10f. Zip Code 20860 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter | | 16b. Kind of Business/Industry Self employed | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Mack Wood | | | | 18. Mother's Name (First, Middle, Maiden Surname) Blanche Swain | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Florence E. Wood (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18326 Brooke Road, Sandy Spring, MD 20860 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan F/Srv. | | Date 11/24/99 | | 20c. Location - City or Town, State Alexandria, VA | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC RENAL CELL CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 4 months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number 35635 | | 29d. Date signed (Month, Day, Year) Nov 24, 1999 | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Kenneth Miller M.D. 18111 Prince Phillip Dr, Olney, Md #20832 | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 26 1999 | | | | 32. Registrar's Signature | | | | |

WRC
99-6937-033

PAULINE E. AMEND ITEMS: #208-C PER F.H. 6779 1-13-2000 WR
WICKS AMEND ITEMS: #23 PART 1, 27, 28A-F PER MEO 6778 12-9-99 WR.
Amend #8, 11/24/99, BMW, Montg. Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 99 38238

| | | | | | | | | | | |
|--|---|--|---|---|--|--------------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) PAULINE WICKS | | | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | | | 3. Time of Death 6:10 PM. | |
| | 4a. Facility Name (If not institution, give street and number) 1016 58th. AVE. | | | | 4b. City, Town, or Location of Death FAIRMOUNT HEIGHTS | | | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 577-34-8690 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 97 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) JUNE 11, 1912 | | 9. Birthplace (State or Foreign Country) NC | | 10a. State MD | | 10b. County PRINCE GEORGES | | 10c. City, Town or Location FAIRMOUNT HEIGHTS | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 1016 58th AVENUE | | | | 10f. Zip Code 20043 | | | | 10g. Citizen of What Country? UNITED STATES | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC | | | | 16b. Kind of Business/Industry PRIVATE INDUSTRY | |
| | 17. Father's Name (First, Middle, Last) UNK | | | | 18. Mother's Name (First, Middle, Maiden Surname) CARRIE MURRAY | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) GEORGE WICKS, JR. - SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 649 F Street, N.E., Washington, DC 20002 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHELTENHAM VETERANS CEMETERY Maryland National Cem. | | Date 11/29/99 | | 20c. Location - City or Town, State Cheltenham, MD Laurel, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility R. M. Horton Co. Morticians, Inc. 500 Kennedy St., N.W., Wash., DC 20011 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOTHERMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) Found: 11-18-99 | | 28b. Time of Injury Found: 3:37 P | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME | | | | 28d. Describe how injury occurred ENVIROMENTAL EXPOSURE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1016 58th AVE. FAIRMOUNT HEIGHTS MD | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | |
| 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, no 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-2025.

WRC
99-6936-033

GEORGE B. AMEND ITEMS: #20B C PER F.H

WICKS AMEND ITEMS: #23 PART I, II, 27,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

38239

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) GEORGE B. WICKS, SR. | | 2. Date of Death Month Day Year NOVEMBER 18, 1999 | | 3. Time of Death 6:10 PM. | |
| 4a. Facility Name (If not institution, give street and number) 1016 58th. AVE. | | 4b. City, Town, or Location of Death FAIRMOUNT HEIGHTS | | 4c. County of Death PRINCE GEORGES | |
| 5. Social Security Number 578-14-4800 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 97 Yrs. | |
| 8. Date of Birth (Month, Day, Year) JULY 22, 1912 | | 9. Birthplace (State or Foreign Country) NY | | | |
| Usual Residence of Decedent | | 10a. State MD | | 10b. County PRINCE GEORGES | |
| 10c. City, Town or Location FAIRMOUNT HEIGHTS | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 1016 58th Avenue | | 10f. Zip Code 20043 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECURITY GUARD | |
| 16b. Kind of Business/Industry FEDERAL GOVERNMENT | | 17. Father's Name (First, Middle, Last) UNK | | 18. Mother's Name (First, Middle, Maiden Surname) IRENE MOSBY | |
| 19a. Informant's Name/Relationship (Type, Print) GEORGE WICKS, JR. - SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 649 F Street, N.E., Washington, DC 20002 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, funeral home, or other place) CHELTENHAM CEMETERY, MARYLAND NATIONAL | | 20c. Location - City or Town, State Cheltenham, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility R. N. HORTON CO. MORTICIANS, INC. 500 KENNEDY STREET, N.W., DC, 20011 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOTHERMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACUTE PYELONEPHRITIS: CARDIAC HYPERTROPHY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE PYELONEPHRITIS: CARDIAC HYPERTROPHY | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. Date of Injury (Month, Day Year) Found: 11-18-99 | | 28b. Time of Injury Found: 3:37 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred ENVIRONMENTAL EXPOSURE | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1016 58th AVE. FAIRMOUNT HEIGHTS MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) NOVEMBER 19, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #5, 10e, 19a, 11/30/99, EMW, Montg Co
 Amend #17, 11/22/99, EMW, Montg Co
 State of Maryland / Department of Health and Mental Hygiene
 Montgomery County **Certificate of Death**

Reg. No. 99 38240

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sadie Ethel White | | | | 2. Date of Death Month Day Year November 18, 1999 | | 3. Time of Death 10:31 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery County | |
| Funeral Director | 5. Social Security Number 519-60-5344 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 98 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) November 15, 1901 | | 9. Birthplace (State or Foreign Country) Washington, D.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery County | | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 1516 Fenwick Lane #401 1316 | | | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher | | 16b. Kind of Business/Industry Education | | |
| 17. Father's Name (First, Middle, Last) Robert James Washington, Sr. - Brother | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Lee Kemper | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gloria Washington Cooper - Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8750 Georgia Avenue #1503B Silver Spring, Maryland. 20910 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center | | Date November 20, 1999 | | 20c. Location - City or Town, State Washington D.C. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Hypertension | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Ruth Kevers-Cohen MD | | | | 29c. License number D33159 | | 29d. Date signed (Month, Day, Year) November 19, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kevers-Cohen M.D. 8700 Georgia Ave #400 Silver Spring MD 20910 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38241

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND JOHN WHITAKER

2. Date of Death

Month
NovDay
18Year
99

3. Time of Death

9:30am

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

095-10-9952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 21, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1944

If Yes, Give Year or Dates: to 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Chemical

17. Father's Name (First, Middle, Last)

Millard Whitaker

18. Mother's Name (First, Middle, Maiden Surname)

Leola Frances Stearns

19a. Informant's Name/Relationship (Type, Print)

Barbara Beaubien (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3824 Survey Circle Bonita Springs, Fla. 34134

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Nov. 19, 1999

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andres Salazar MD

29c. License number

D51051

29d. Date signed (Month, Day, Year)

November 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Name: Raymond Whitaker

⑥ 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

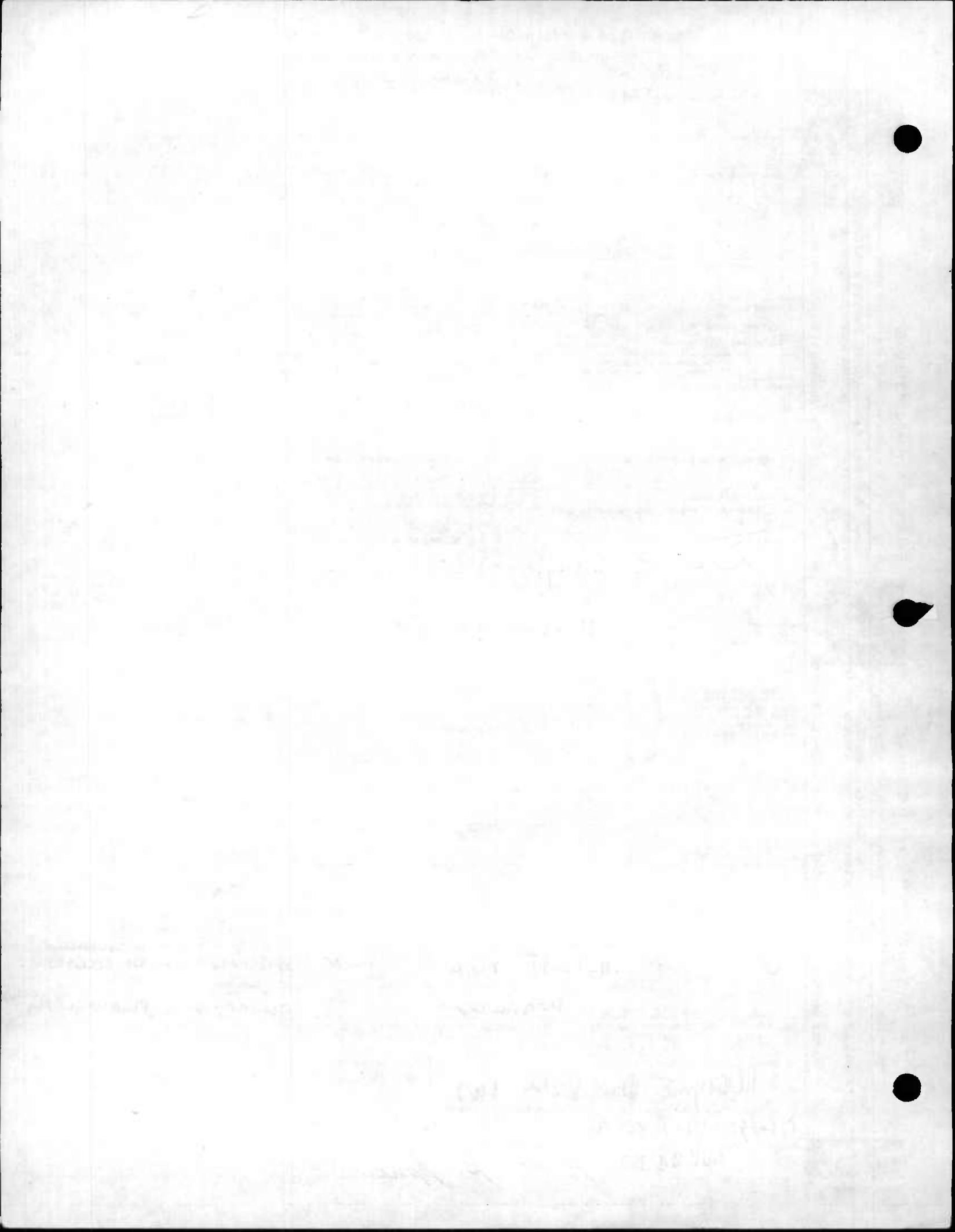
Reg. No.

99 38242

| | | | | | | | | | | | | | | | |
|---|---|---|---|--------------------------------|---|---|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Diana Katherine Westley | | | | 2. Date of Death Month Day Year NOVEMBER 22, 1999 | | | | 3. Time of Death 0750 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) CHERRY HILL AND COLLIER ROAD | | | | 4b. City, Town, or Location of Death BELTSVILLE | | | | 4c. County of Death PRINCE GEORGES | | | | | | |
| Funeral Director | 5. Social Security Number 212-64-3962 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 22, 1963 | | 9. Birthplace (State or Foreign Country) New York | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 350 Scott Drive | | | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? United States | | | | | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Piece Rate Worker | | | | 16b. Kind of Business/Industry Sheltered Work Shop | | | | | | |
| | 17. Father's Name (First, Middle, Last) Francis Westley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Rose Ruddy | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Francis Westley/Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12016 Golden Twig Court, Gaithersburg, MD 20878 | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park | | 20c. Location - City or Town, State Rockville, Maryland | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee [Signature] M00803 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 11-22-99 | | 28b. Time of Injury 7:49A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred PASSOVER IN VAN COLLISION | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Cherry Hill, Prince Georges | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier [Signature] | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 23, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANN A. KOREN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38243

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN LAWRENCE WEISS, JR.

2. Date of Death
Month Day Year
NOVEMBER 20, 19993. Time of Death
11:50 PM

4a. Facility Name (If not institution, give street and number)

Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

219-18-8401

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/24/24

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39 Coastal Dr.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Operations Manager

16b. Kind of Business/Industry

Wholesale
Liquor Co.

17. Father's Name (First, Middle, Last)

John Lawrence Weiss, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Doyle

19a. Informant's Name/Relationship (Type, Print)

Charlotte Weiss/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 Coastal Dr. Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Cemetery

Date

11/23/99 Easton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease

5 years

Due to (or as a consequence of):

Insulin Dependent Diabetes Mellitus

5 years

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia; Vascular Type

Multiple CVA, Anemia

Chronic Renal Disease; Cirrhosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

B46257

29d. Date signed (Month, Day, Year)

November 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edwin T. Castaneda, M.D.

9714 Healthway Drive, Berlin, MD 21811

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Weiss, John

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38244

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICIA

YDOATE

2. Date of Death

NOVEMBER 16, 1999

3. Time of Death

10:00 PM

4a. Facility Name (If not Institution, give street and number)

SHADY GROVE NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

153-50-7885

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 15, 1953

9. Birthplace (State or Foreign Country)

Colombia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

226 Kentlands Boulevard

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bank Examiner

16b. Kind of Business/Industry

U. S. Treasury

17. Father's Name (First, Middle, Last)

Alfonso Ydoate

18. Mother's Name (First, Middle, Maiden Surname)

Soledad Ospina

19a. Informant's Name/Relationship (Type, Print)

Soledad Ydoate, mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

78 Washington Avenue, Iselin, NJ 08830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Nov 20

1999

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic ovarian cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George A. Sotos MD

29c. License number

D43083

29d. Date signed (Month, Day, Year)

NOVEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GEORGE A. SOTOS, M.D., 9707 MEDICAL CENTER DRIVE, #300 ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38245

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) TOMMY LEE YOST | | | | 2. Date of Death Month November Day 18 Year 1999 | | | | 3. Time of Death 3:50 PM | |
| 4a. Facility Name (If not institution, give street and number) 6710 Dorsey Road | | | | 4b. City, Town, or Location of Death Gaithersburg | | | | 4c. County of Death Montgomery | |
| 5. Social Security Number 217-12-3025 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 6 1921 | | 9. Birthplace (State or Foreign Country) North Carolina | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6710 Dorsey Road | | | | 10f. Zip Code 20882 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | | | 16b. Kind of Business/Industry Electric Company | |
| 17. Father's Name (First, Middle, Last) David Fred Yost | | | | 18. Mother's Name (First, Middle, Maiden Surname) Daisy Hendricks | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ramona Dove Yost / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6710 Dorsey Road, Gaithersburg, Maryland 20882 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Laytonsville Cemetery | | | | Date 11/22/99 | | 20c. Location - City or Town, State Laytonsville, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 15 minutes | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | | | 29c. License number D14057 | | 29d. Date signed (Month, Day, Year) November 18, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lewis Kellert, MD, 4000 Olney, Laytonsville Rd. Olney, Maryland 20832 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature  | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND#20b PER F.H. G778 12-7-99 J.A.

Reg. No. 99 38216

| | | | | | |
|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) IRVIN J. AMDUR | | 2. Date of Death Month Day Year NOVEMBER 25, 1999 | | 3. Time of Death 11:57 AM |
| | 4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 217-09-1217 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | 8. Date of Birth (Month, Day, Year) MAY 19, 1917 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 6819 TIMBERLANE ROAD | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN | | 16b. Kind of Business/Industry INSURANCE |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) SAMUEL AMDUR | | 18. Mother's Name (First, Middle, Maiden Surname) RHEA LEVINSON | | |
| | 19a. Informant's Name/Relationship (Type, Print) BELLE AMDUR / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6819 TIMBERLANE ROAD - BALTIMORE, MD 21209 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) SEAR'S EMUNAH | | 20c. Location - City or Town, State ROSEDALE, MD | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| Physician /Medical Examiner | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 2 WEEKS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| State Registrar | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| A-4 | 29b. Signature and title of certifier  | | 29c. License number D0051896 | | 29d. Date signed (Month, Day, Year) 11/26/99 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS MALINOW 3635 OLD COURT RD BALTO. MD 21208 | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint handwritten notes at the bottom of the page]

DHHH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38248

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TARMARA

Bailey

2. Date of Death

Month Day Year
DEC 02, 1999

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

Millennium - of Franklin Square

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

315-88-9356

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

25 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 13, 1974

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4021 ARDLEY AVENUE

10f. Zip Code

21213

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9+H GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

CARL W.

BAILEY SR.

18. Mother's Name (First, Middle, Maiden Surname)

JOYCE

BEN

19a. Informant's Name/Relationship (Type, Print)

CARL W. BAILEY SR. (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4021 ARDLEY AVENUE, BALTIMORE, MD. 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY

Date

12-06-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO. MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. TERMINAL HIV DISEASE

Due to (or as a consequence of):

b. CNS TOXOPLASMOSIS / INTRACRANIAL SPACE

Due to (or as a consequence of):

c. MAI INFECTION

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

UNKNOWN

SINCE 11/99

SINCE 8/99

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel A Wolde Rufael, MD

29c. License number

D47717

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEL A. WOLDE RUFEL, MD, 101 CATHEDRAL ST, BALTIMORE, MD, 21201

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38249

| | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Florence Louise Barrett | | | | 2. Date of Death Month Day Year DEC 1, 1999 | | | | 3. Time of Death 6:05 AM | |
| | 4a. Facility Name (If not institution, give street and number) 4791 Bonnie Branch Road | | | | 4b. City, Town, or Location of Death Ellicott City | | | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 213-34-1949 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 9, 1936 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | | | 10b. County Howard | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Ellicott City | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 4791 Bonnie Branch Road | | | | 10f. Zip Code 21043 | | | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Admin. Asst. to Secretary of Health | | | | 16b. Kind of Business/Industry State of Maryland | |
| | 17. Father's Name (First, Middle, Last) Walter Obara | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anne M. Punzak | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Burke L. Barrett - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4791 Bonnie Branch Rd., Ellicott City, Md. 21043 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | Date 12/4/99 | | 20c. Location - City or Town, State Elkridge, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge Mem. Park, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. OVARIAN CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 18 mos | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier William P. McSwiney | | | | 29c. License number D16801 | | |
| 29d. Date signed (Month, Day, Year) Dec 2, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 301 St. Paul Place Baltimore, MD 21202 | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DEC 07 1938
James H. Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38250

Baltimore, Maryland 21215-0020
 Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

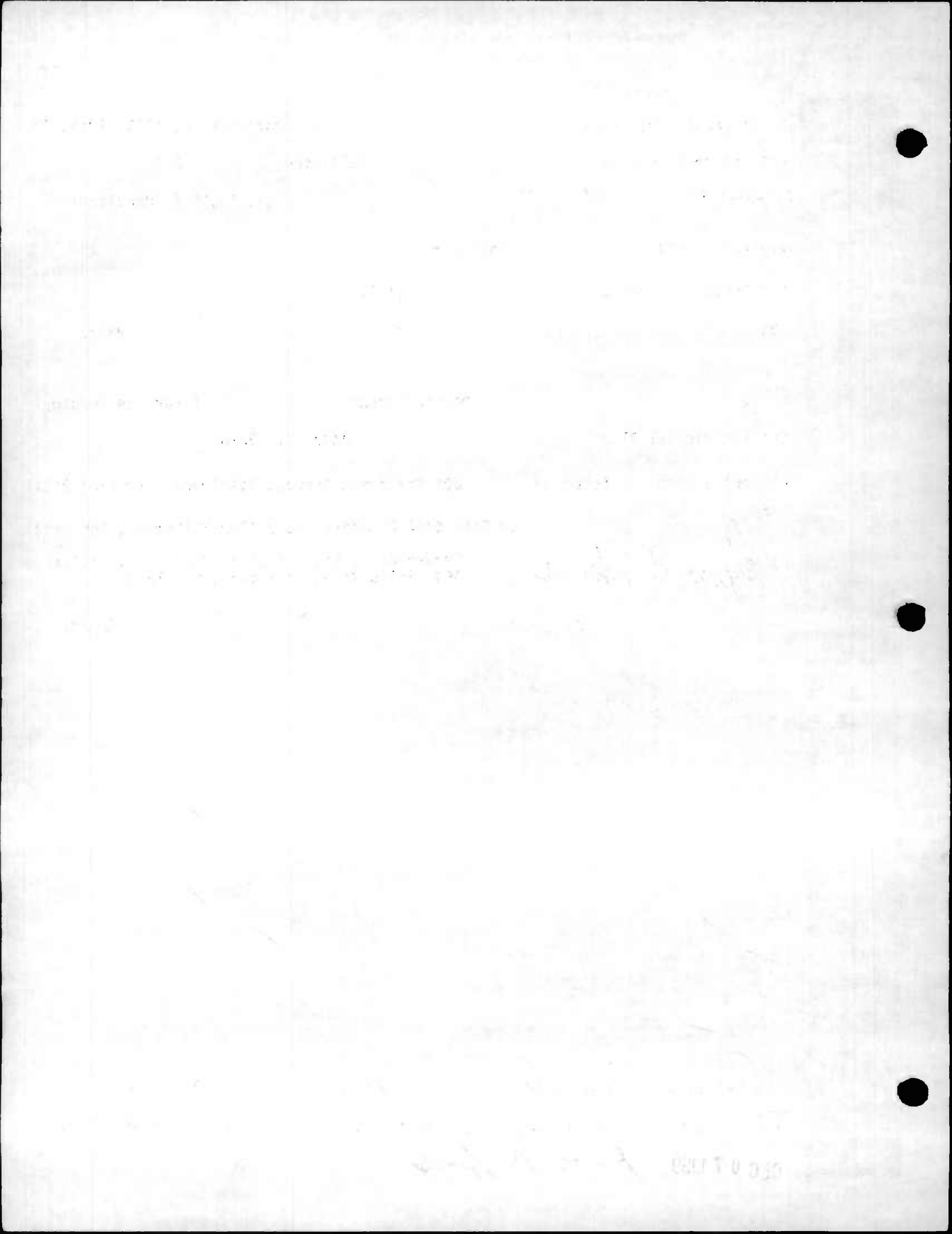
Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Margaret A. Blum | | | | 2. Date of Death Month November Day 30 Year 1999 | | 3. Time of Death 10:00 AM | |
| 4a. Facility Name (If not institution, give street and number) 604 Craycombe Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 214-03-1969 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 10, 1915 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 604 Craycombe Avenue | | | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Worker | | 16b. Kind of Business/Industry Insurance Company | |
| 17. Father's Name (First, Middle, Last) Charles Michael Blum | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Anna K. Grandy | | | |
| 19a. Informant's Name/Relationship (Type, Print) Katherine Blum Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Craycombe Avenue, Baltimore, Maryland 21211 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | | | | |
| | | 20c. Location - City or Town, State 12/3/1999 Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diverticulitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D23076 | | 29d. Date signed (Month, Day, Year) 12-1-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L DIAMOND 3730 FALLS RD BAL MD 21211 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature | | | |

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38251

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FREIDA C BENNETT

2. Date of Death
Month Day Year

December 2 1999 5:46 P.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

BALTIMORE

5. Social Security Number

419-30-3564

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Dec 1 1928

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

314 Nicholson Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Joseph Ramsey

18. Mother's Name (First, Middle, Maiden Summa)

Emma Massingel

19a. Informant's Name/Relationship (Type, Print)

Brenda Books / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12235 Eastern Ave. Chase MD 21027

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Cemetery 12/6/99

Date

20c. Location - City or Town, State

Baltimore MD.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

1 Day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Bilateral Pneumonia

Due to (or as a consequence of):

2 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Respiratory Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Chris Park

29c. License number

RD 187294

29d. Date signed (Month, Day, Year)

12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHRIS PARK 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Benjamin S Sparks

State
Registrar

ORIGINAL

Freida Bennett
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23c-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OFF. 1. 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KATHERINE BURTON AMEND ITEMS: #23 PART I, 27-28A-F PER MEO G778 12-17-99 38252

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Katherine Denise Burton | | 2. Date of Death Month Day Year DECEMBER 2, 1999 | | 3. Time of Death 0731 AM | |
| 4a. Facility Name (If not institution, give street and number) REAR OF 518 EAST NORTH AVENUE | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA |
| 5. Social Security Number 220-84-6569 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 36 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 09-03-63 |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County NA | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. Street and Number 2005 E. 30th Street | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled | | 16b. Kind of Business/Industry unemployed | |
| 17. Father's Name (First, Middle, Last) Thomas J. Burton | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel JONES Johnson | | |
| 19a. Informant's Name/Relationship (Type, Print) Mabel Nixon | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 2005 E. 30th Street Baltimore, Maryland | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem. Pk. Cem. 12-06-99 Randallstown, MD | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HYPOTHERMIA e. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 12-2-99 | | 28b. Time of Injury Found: A 7:10 | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred EXPOSED TO COLD | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND OUTSIDE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) REAR OF 518 E. NORTH AVE. BALTIMORE, MD | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DECEMBER 2, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38253

| | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Roosevelt Booker Jr. | | | | 2. Date of Death Month NOVEMBER Day 30 Year 1999 | | | | 3. Time of Death 1150 AM | |
| | 4a. Facility Name (If not institution, give street and number) TOWNHOUSE MOTEL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 213-54-2192 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) 12 22 49 | | 9. Birthplace (State or Foreign Country) M.D. | |
| | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2848 Oakford Ave | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Stocker | | | | 16b. Kind of Business/Industry B Green & Company | | |
| 17. Father's Name (First, Middle, Last) Roosevelt Booker Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Inell McClendon | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Elvira Booker-Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2930 Oakford Ave, Baltimore Md 21215 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet | | Date 12/7/99 | | 20c. Location - City or Town, State Owings Mills, Md | | |
| 21. Signature of Funeral Service Licensee <i>Jerome A. Thompson</i> | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC AND COCAINE INTOXICATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 11-30-99 | | 28b. Time of Injury UNK M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN MOTEL | | | | 28f. Location (Street and Number or Rural Route Number City or Town, State) Reisterstown Rd. BALTI MD | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>John Locke</i> | | | | 29c. License number O.C.M.E. | | | | 29d. Date signed (Month, Day, Year) DECEMBER 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Locke MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James H. Thompson

James H. Thompson

Oct 11 1880

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38254

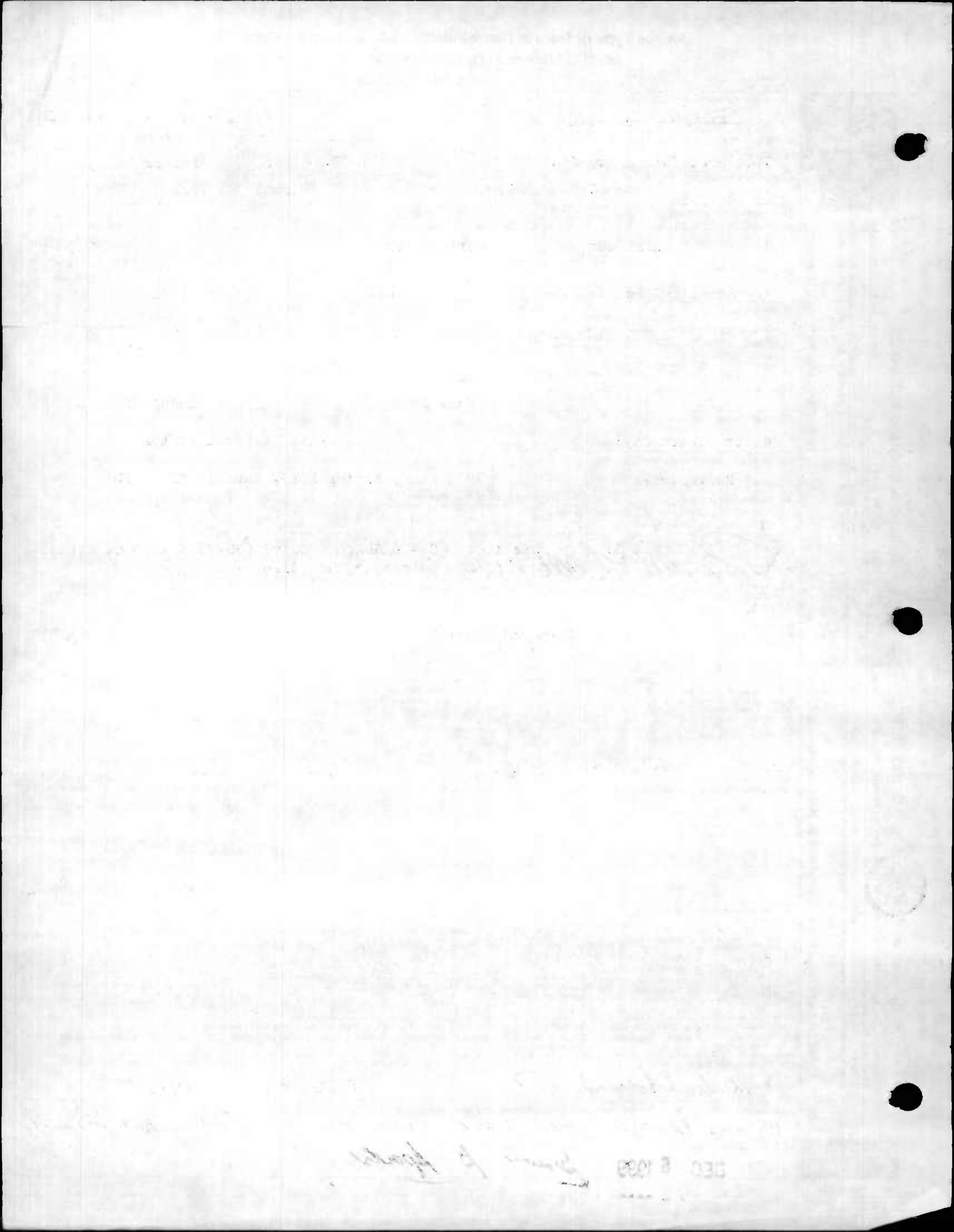
AMEND: ITEM: 1 PER 1 PER MD G778 12-2-99 WR. **Certificate of Death**

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Brooks, Irene</u> IRENE E. BROOKS | | | | 2. Date of Death Month Day Year October 18 99 | | 3. Time of Death 6:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) 9014 Rhode Island Ave #406 | | | | 4b. City, Town, or Location of Death College Park | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 212-20-1153 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) June 30, 1922 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location College Park | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 9014 Rhode Island Ave #406 | | 10f. Zip Code 20740 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fast Food | | 16b. Kind of Business/Industry School System | | 17. Father's Name (First, Middle, Last) Walter Albert Doyle | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Lydia Margaret Benton | | 19a. Informant's Name/Relationship (Type, Print) Ruby Bolt/sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7910 Sandy Spring Road, Laurel, MD 20707 | | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | 21. Signature of Funeral Service Licensee <u>Ronald S. Wade, Director</u> | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Emphysema</u> Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>Michael Berard, MD</u> | | 29c. License number DZ6287 | | 29d. Date signed (Month, Day, Year) 11/18/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL BERARD MD 7305 BALTIMORE AVE 107 College Park MD 20740 | | 31. Date filed (Month, Day, Year) DEC 6 1999 | | 32. Registrar's Signature <u>Berard</u> | | 33. Registrar's Title Registrar | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Handwritten signature

DEC 8 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38255

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Elizabeth Chambers

2. Date of Death

Month
DEC

Day

3,

Year

1999

3. Time of Death

06:05 AM

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-34-6169

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

JAN 12, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

965 Glenbrook Court

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

5

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Long Term Care

17. Father's Name (First, Middle, Last)

Howard H. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Helen Shalte

19a. Informant's Name/Relationship (Type, Print)

Oscar Chambers - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

965 Glenbrook Court, Westminster, Md. 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

12/06/99

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. multiple myeloma

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

28 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural

5 ☐ Pending investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

025205

29d. Date signed (Month, Day, Year)

December 3, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W.A. Riley G-BMC 6701 N. Charles St. Balto. and

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

[Signature]

20205

State Registrar

Chambers, Margaret 12/3/99 @ 0605

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22a or 22b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

944

1944

1944

1944

1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38256

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leon A. Call

2. Date of Death

Month

Day

Year

November 29, 1999

3. Time of Death

6:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

MD

5. Social Security Number

063-32-2995

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

APR 2, 1941

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

NY

10b. County

Jeff

10c. City, Town or Location

Antwerp

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

37795 Old US Route 11

10f. Zip Code

13608

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Superintendent

16b. Kind of Business/Industry

Paper (Champion)

17. Father's Name (First, Middle, Last)

Roscoe G. Call

18. Mother's Name (First, Middle, Maiden Surname)

Yolaide Wicks

19a. Informant's Name/Relationship (Type, Print)

Barbara Call - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37795 Old US Route 11, Antwerp, NY 13608

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Michaels Cemetery

Data

12/03/99

20c. Location - City or Town, State

Antwerp, New York

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Leiomysarcoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HENRY TAN MD SINAI HOSPITAL OF BALTIMORE
2401 WEST BELVEDERE AVE, BALTIMORE, MD, 21215

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

LEON A. CALL
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 305A.

Handwritten signature

DEC 9 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38257

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michelle Nicole Carter Clay

2. Date of Death
Month Day Year
December 1 19993. Time of Death
13:45Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

215-88-4338

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1/24/70

9. Birthplace (State or Foreign Country)

md.

Usual Residence of Decedent

10a. State

md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

1549 Montpelier St.

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

PACKER

16b. Kind of Business/Industry

Factory Work

17. Father's Name (First, Middle, Last)

John E. Carter

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Faulkner

19a. Informant's Name/Relationship (Type, Print)

Brian Clay

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1549 Montpelier St. Baltimore, Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus

Date

12/8/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Patricia B. Batts

22. Name and Address of Facility

Bells Funeral Home
1129 N. CAROLINE ST. BALTIMORE, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Status Asthmaticus

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda Wolfenden, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda Wolfenden, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

B. A. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-552-8000.

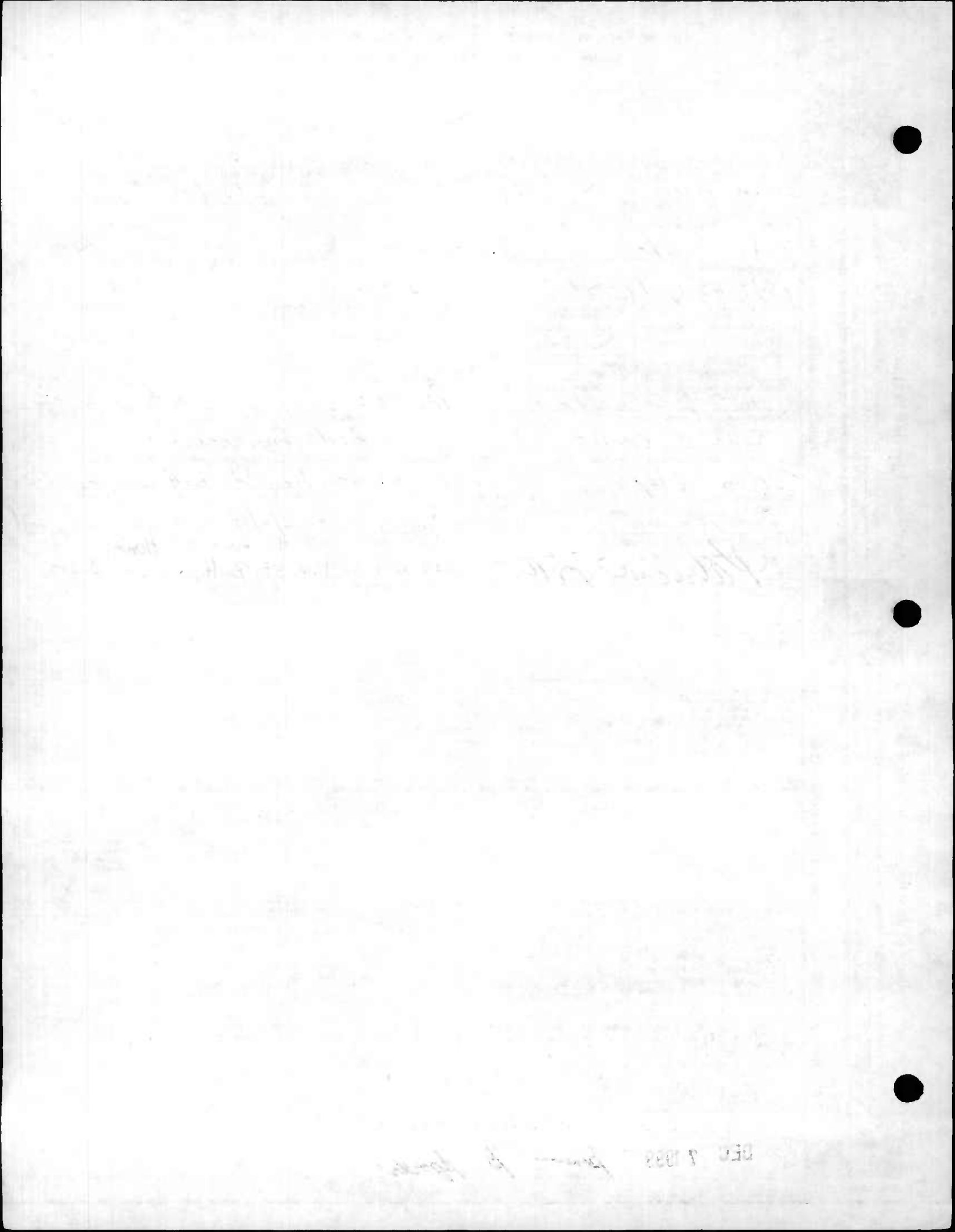
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38258

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BOBBY H. CHANNELS | | | | 2. Date of Death Month Day Year Dec. 5, 1999 | | 3. Time of Death 3:10 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 218-36-5010 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 60 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 21, 1939 | | 9. Birthplace (State or Foreign Country) West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 438 Riverdale Road | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Anchor Trucking Co. | | |
| 17. Father's Name (First, Middle, Last) Walter Channels | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Willmoth | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Alice C. Channels (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 438 Riverdale Road Severna Park, MD. 21146 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | Date 12/7/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STROKE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death 6 days | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTRIC LYMPHOMA | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number DO2519 | | 29d. Date signed (Month, Day, Year) Dec 6 99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard E Fisher Crain Towers GLEN BURNIE | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

DEC 1 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38259

| | | | | | | | | | | |
|--|--|-------------------------------|---|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLADYS H COMPTON | | | | | 2. Date of Death Month Day Year DEC 5 1999 | | 3. Time of Death 3:30 am | | |
| | 4a. Facility Name (If not institution, give street and number) KNOLLWOOD MANOR | | | | | 4b. City, Town, or Location of Death MILLERSVILLE | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 179-20-6932 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN 1 1927 | | 9. Birthplace (State or Foreign Country) North Carolina | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD. | | 10b. County Harford | | 10c. City, Town or Location Joppa | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 53 Old Sound Road | | | | | 10f. Zip Code 21085 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Libraian | | | 16b. Kind of Business/Industry MD. General Hospital | | |
| 17. Father's Name (First, Middle, Last) Toy H Hill | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Geneva McCoury | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Larry Compton / son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 Cottonwood Drive Severna Park Md. 21146 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 12/6/99 | | | 20c. Location - City or Town, State Baltimore Md. | | | | |
| 21. Signature of Funeral Service Licensee R. Terry Connelly | | | | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LIVER FAILURE | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) a. LIVER FAILURE Due to (or as a consequence of): | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Auto-Immune Hepatitis | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier R. Terry Connelly | | | | | 29c. License number 11753 | | 29d. Date signed (Month, Day, Year) 12/6/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Old Court Road, Millersville, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DEC 7 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38260

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ivy Janet Cearfoss | | | | 2. Date of Death Month DECEMBER Day 3 Year 1999 | | 3. Time of Death 11:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-05-3099 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) June 27, 1917 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Timonium | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 2 Ballindine Ct. | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) N/A | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator | | 16b. Kind of Business/Industry Communication | | | |
| | 17. Father's Name (First, Middle, Last) Charles Schimp | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Musgiller | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Lazaro/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Yearling Way, Lutherville, MD 21093 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Date Dec. 6, 1999 | | 20c. Location - City or Town, State Baltimore, MD | |
| | 21. Signature of Funeral Service Director  Michael J. Flagle | | 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE GASTRO-INTESTINAL HEMORRHAGE DUE TO a. Due to (or as a consequence of): GASTRIC LYMPHOMA b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 YEARS | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  Natividad D. DeLeon, M.D. | | | | 29c. License number D 19508 | | 29d. Date signed (Month, Day, Year) Dec. 3, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. DELEON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) - - DEC 7 1999 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

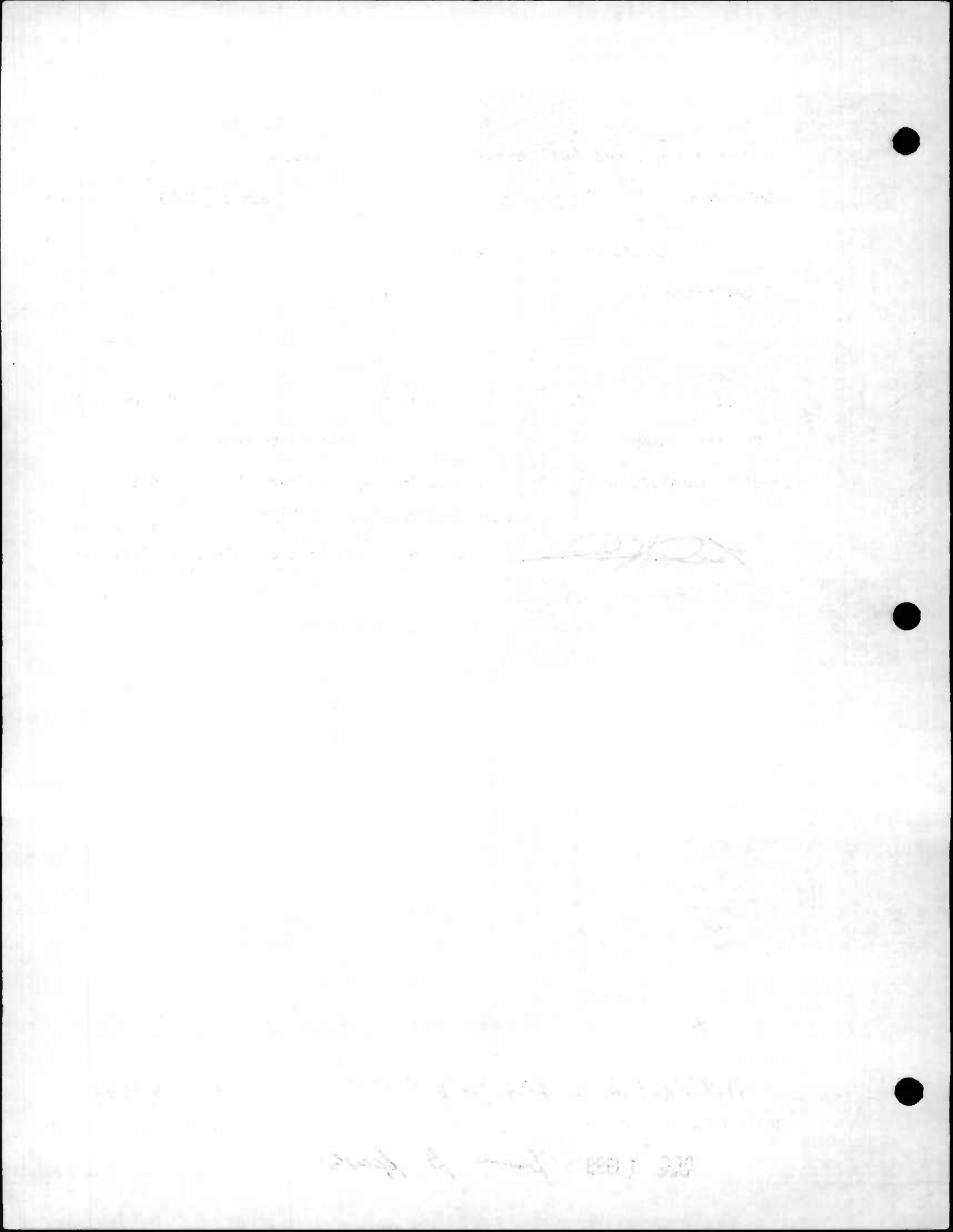
Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38261

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUTHER WALTER COX

2. Date of Death

Month Day Year

11-30-99

3. Time of Death

13-20 #13

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2603 Kenwood Dr.

4b. City, Town, or Location of Death

Joppa

4c. County of Death

Harford

5. Social Security Number

220-14-7349

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 1921

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2603 Kenwood Drive

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yrs.College (1-4or 5+)
n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Expeditor

16b. Kind of Business/Industry

Glenn L. Martin

17. Father's Name (First, Middle, Last)

Clarence Cox

18. Mother's Name (First, Middle, Maiden Surname)

Anna (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mildred A. Cox (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2603 Kenwood Drive Joppa, Maryland 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

12/4/99

20c. Location - City or Town, State

Baltimore, Maryland 21224

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home
11750 Belair Road Kingsville, Maryland 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTRO INTESTINAL BLEED

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CA PROSTATE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

E. F. Lassahn

29c. License number

00000

29d. Date signed (Month, Day, Year)

11-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. P. BASH M D 218 GULF AVE BELAIR MD 21014 410 879 6564

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

D. B. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38262

| | | | | | | | | | | |
|---|---|---|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RUTH CANTRELL | | | | 2. Date of Death Month DECEMBER , Day 1 , Year 1999 | | | | 3. Time of Death 0745 | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL | | | | 4b. City, Town, or Location of Death RANDALSTOWN | | | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 220-12-8297 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | 8. Date of Birth (Month, Day, Year) Dec. 6, 1914 | 9. Birthplace (State or Foreign Country) Tennessee | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore County | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 52 Left Wing Drive | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) 2 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary | | | 16b. Kind of Business/Industry Law Industry | | | |
| 17. Father's Name (First, Middle, Last) Jesse Cantrell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie Vantregge | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John F. Mueller | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Box Circle Baltimore, Maryland 21221 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hearn Hill Cemetery | | Date 12-7-1999 | | 20c. Location - City or Town, State Watertown, Tennessee | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION, DEPRESSION | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, DEPRESSION | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | | | 29c. License number D 37333 | | 29d. Date signed (Month, Day, Year) DECEMBER 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. RAVI MD, NHC, BALTO. MD 21133 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38263

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

BERNARD

COATES

2. Date of Death

Month 12 Day 7 Year 99

3. Time of Death

10:00 a.m.

4a. Facility Name (If not institution, give street and number)

102 Berlin Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel Co.

5. Social Security Number

214-26-0722

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 6 Day 2 Year 29

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel Co.

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

102 Berlin Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates May 1951 March 53

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

5 Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Allen Coates

18. Mother's Name (First, Middle, Maiden Surname)

Helen Ruth Griffin

19a. Informant's Name/Relationship (Type, Print)

Allen Coates, Jr./Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4106 Mountwood Road, Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veteran

Date

12/6/99 Crownsville, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

William C. Brown Community Funeral Home
1206 W. North Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Heart Disease

Approximate Interval Between Onset and Death

YRS.

b. Due to (or as a consequence of):

Atherosclerosis

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] John Harker

29c. License number

021716

29d. Date signed (Month, Day, Year)

12/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN HARKNEY, 4000 ANNAPOLIS RD BALTIMORE

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

[Signature] B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1977 12 11

RECEIVED

12/11/77

DEC 11 1977

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38264

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Amanda E. Dash | | | | 2. Date of Death Month Day Year NOV. 28, 1999 | | | | 3. Time of Death 9:00PM | |
| | 4a. Facility Name (If not institution, give street and number) 2118 Whistler Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-20-2013 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 11, 1926 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State MD | | | | 10b. County N/A | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 2118 Whistler Ave. | | | | 10f. Zip Code 21230 | | | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector | | | | 16b. Kind of Business/Industry Glass Manufacturing | |
| | 17. Father's Name (First, Middle, Last) Henry Lewis Letcher | | | | 18. Mother's Name (First, Middle, Maiden Surname) Harriett Elizabeth Hovatter | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) Melvin H. G. Dash, Jr. - son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6459 Loudon Ave., Elkridge, Md. 21075 | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | Date 12/3/99 | | 20c. Location - City or Town, State Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. Atherosclerotic cardiovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension obesity | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier CD Kearney MD | | | | 29c. License number D27860 | |
| | | | | | 29d. Date signed (Month, Day, Year) December 1st, 1999 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHRISTOPHER D KEARNEY MD 700 WASH. BLVD BALTIMORE 21230 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature | | | | | |
| | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 0 7 1959

James H. Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38265

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Mildred H. Dare

2. Date of Death

Month Day Year
Nov. 29, 1999

3. Time of Death

9:21 PM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

215-22-8672

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 7, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

199 Plymouth Lane

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herman Haft

18. Mother's Name (First, Middle, Maiden Surname)

Rose Brodsky

19a. Informant's Name/Relationship (Type, Print)

Barbara Francis - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1506 East Way, Glen Burnie, Md. 21060

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

12/2/99

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. HYPERTENSIVE ARTERIOSCLEROTIC

Due to (or as a consequence of):

c. CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

SUDDEN

YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN ST., BALTIMORE, MD. 210201

State
Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2020.

Physician
(Medical
Examiner)

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DARE, MILDRED 11/29/99

AH

[Faint, illegible handwriting covering the majority of the page]

[Faint handwriting] DEC 1 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38266

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) William Devillasee | | | | 2. Date of Death Month 12 Day 04 Year 99 | | 3. Time of Death 1500 | |
| 4a. Facility Name (If not institution, give street and number) Genesis HOMEWOOD | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| 5. Social Security Number 220016217 A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) 01 24 21 | |
| 9. Birthplace (State or Foreign Country) | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1400 E. Madison St. APT 810 | | | | 10f. Zip Code 21205 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) no schooling College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | 16b. Kind of Business/Industry Welding + welding | |
| 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lucy Devillasee | | | |
| 19a. Informant's Name/Relationship (Type, Print) Emma Devillasee | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 N. Ann St. Baltimore 21231 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM | | 20c. Location - City or Town, State 12/4/99 Landsdown, MD | | 20d. Date | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. Caroline St. BALTO MD. 21213 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. glioblastoma BRAIN Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D17537 | | 29d. Date signed (Month, Day, Year) 12-6-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DARSHAN S. SALUJANG 1600 W. MOUNT Royal Ave, Balto 21217 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

M

State
Registrar

[Faint handwritten scribbles]

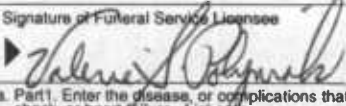
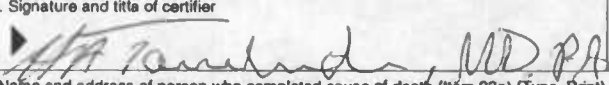
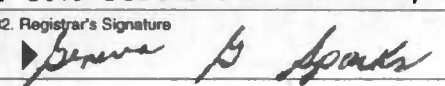
DEC 3 1993

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38267

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARION A. DARLACK | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 7:00 p.m. | |
| | 4a. Facility Name (If not Institution, give street and number) 2058 Kurtz Avenue | | | | 4b. City, Town, or Location of Death Pasadena | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 219-07-9073 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 26, 1921 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 2058 Kurtz Avenue | | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crane Operator | | 16b. Kind of Business/Industry Eastern Stainless Steel | | |
| 17. Father's Name (First, Middle, Last) George Darlack | | | | 18. Mother's Name (First, Middle, Maiden Surname) Veronica Huppa | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. James M. Darlack (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1639 Parkcrest Circle Reston, Virginia 20190 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. | | Date 12/8/99 | | 20c. Location - City or Town, State Owings Mills, Md. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. ASCVD, VENTRICULAR Due to (or as a consequence of): c. ARTERY THROMBIA Due to (or as a consequence of): d. | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D-21864 | | 29d. Date signed (Month, Day, Year) 12/6/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamid A. Towhidian Md. 8679 Fort Smallwood Road, Pasadena, Md. 21122 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature  | | | | | | |

ORIGINAL

1938

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38268

| | | | | | | | | | | |
|---|---|-------------------------------|---|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CARMELINA CELEIA DECKER | | | | | | 2. Date of Death Month Day Year DECEMBER 2, 1999 | | 3. Time of Death 3:45 a.m. | |
| | 4e. Facility Name (If not Institution, give street and number) 3017 Center Drive | | | | | | 4b. City, Town, or Location of Death Ellicott City | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 216-36-5206 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) May 9, 1904 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3017 Center Drive | | | | 10f. Zip Code 21042 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Mario Restivo | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosina (Restivo) | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rosemary Hall (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3017 Center Drive, Ellicott City, MD 21042 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery | | Date 12/4/99 | | 20c. Location - City or Town, State Woodlawn, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility WITZKE FUNERAL HOME 1630 Edmondson Avenue, Catonsville, MD 21228 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier Pritham S. Saini MD | | 29c. License number D28998 | | 29d. Date signed (Month, Day, Year) Dec 2, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITHAM S. SAINI MD 9101 Cherry Ln Suite 211, Laurel MD 20708 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AA

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38269**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS ANN DEL VECCHIO

2. Date of Death

Month Day Year
Dec. 2, 1999

3. Time of Death

10:50 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1434 Glenville Road

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

079-22-7411

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 15, 1925

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1434 Glenville Road

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Middle School

17. Father's Name (First, Middle, Last)

Francis J. Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Mildred A. Richards

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Przybylski (Dghtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1434 Glenville Road, Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory

Date

12/6/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction
Due to (or as a consequence of):b. Cerebrovascular accident
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Hypertension

② Diabetes mellitus

③ Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27975

29d. Date signed (Month, Day, Year)

12/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David McClure M.D.

615 W. MacPhail Road, Bel Air, MD 21014

State
Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

DEC 0 1 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38270

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Lewis Fisher Sr.

2. Date of Death
Month Day Year

December 7, 1999

3. Time of Death

8:20 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-16-5366

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

May 3, 1919

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State
Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8247 Bullneck Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9 yrs.

College (14or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Edward Monroe Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Elmore

19a. Informant's Name/Relationship (Type, Print)

Clara Fisher wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8247 Bullneck Rd. Dundalk Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill

Data
Dec 9, 1999

20c. Location - City or Town, State

Middle River

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connolly Funeral Home Of Dundalk
7110 Sollers Point Rd. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Gram Positive Septicemia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Acute on Chronic Renal Failure

Due to (or as a consequence of):

2 Days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiomyopathy

Valvular Cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Marco Zamora, MD

29c. License number

D 40819

29d. Date signed (Month, Day, Year)

December 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Marco Zamora 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Benjamin Sparks

State
Registrar

Handwritten signature

DEC 1 1930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38271

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Henry Fitzgerald

2. Date of Death
Month Day Year

December 06, 1999

3. Time of Death

3:58 AM

4a. Facility Name (If not institution, give street and number)

Oak Crest Village Care Center

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

096-05-0737

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 11, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inade City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Blvd., Frederick House

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Commodities Broker

16b. Kind of Business/Industry

Commodities

Self-Employed

17. Father's Name (First, Middle, Last)

John Fitzgerald

18. Mother's Name (First, Middle, Maiden Surname)

Mary Clifford

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary F. Fitzgerald (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd., Frederick House, Balt., MD 21234

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Vet. Cem.

Date

12/9/99

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Brian A. Wheeler

22. Name and Address of Facility

Schimunek Funeral Home, Inc.

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Multinfarct Dementia

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

c. CVA

Due to (or as a consequence of):

d.

years.
years.Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection

Dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan Weiner MD

29c. License number

D34941

29d. Date signed (Month, Day, Year)

12-6-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan G. Weiner MD 8800 Walther Blvd Parkville, Md 21234

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Benjamin B. Sparks

State
RegistrarJohn Fitzgerald
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 0 7 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38272**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leroy Gruber

2. Date of Death

Month Day Year
Nov 30 1999

3. Time of Death

12:05 Am

4a. Facility Name (If not institution, give street and number)

St Agnes health care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220183985

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 26, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5240 Kerger Rd.

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Insulator/Asbestos Removal

16b. Kind of Business/Industry

Heat & Frost Engineer

17. Father's Name (First, Middle, Last)

Shriver Gruber

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth White

19a. Informant's Name/Relationship (Type, Print)

Betty Jane Gruber - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5240 Kerger Rd., Ellicott City, Md. 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Crm.

Date

12/4/99

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute renal Failure

Due to (or as a consequence of):

b. Right Kidney tumor

Due to (or as a consequence of):

c. Hyper Calcemia

Due to (or as a consequence of):

d. Complete heart Block.

Approximate Interval Between Onset and Death

one week

one week

one week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

P 12595

29d. Date signed (Month, Day, Year)

NOV 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mustapha Mallah - St Agnes health care

900 Caton Avenue
Baltimore, MD 21228

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

DEC 9 1948

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38273

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elisabeth Dorteia

Glodek

2. Date of Death

December 6, 1999

3. Time of Death

3:15AM

4a. Facility Name (If not institution, give street and number)

Lorien Nursing and Rehabilitation Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-09-1066

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 25, 1913

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4327 Shamrock Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Kirmse

18. Mother's Name (First, Middle, Maiden Surname)

Anna Brokas

19a. Informant's Name/Relationship (Type, Print)

Lewis Glodek - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4327 Shamrock Ave. Baltimore, Md 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

12/07/99

20c. Location - City or Town, State

Towson, Md.

21. Signature of Funeral Service Licensee

Gary R. DiGiovanni

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road, Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke, emphysema,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew K. McNabrey MD

29c. License number

D45757

29d. Date signed (Month, Day, Year)

December 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew McNabrey 5505 Hopkins Bayview Circle BAL MD 21224

State
Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-632-2020.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38274

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | |
|--|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) <i>Harold Major Green</i> | | 2. Date of Death Month <i>December</i> Day <i>6</i> Year <i>1999</i> | | 3. Time of Death <i>300AM</i> | | |
| 4a. Facility Name (If not Institution, give street and number) <i>MARYLAND GENERAL HOSPITAL</i> | | | 4b. City, Town, or Location of Death <i>BALTIMORE CITY</i> | | 4c. County of Death | |
| 5. Social Security Number <i>216-32-4553</i> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>61</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>12-22-1938</i> | |
| 9. Birthplace (State or Foreign Country) <i>Md</i> | | | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State <i>Md</i> | 10b. County <i>NA</i> | 10c. City, Town or Location <i>Baltimore</i> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number <i>1431 CAREY STREET</i> | | | 10f. Zip Code <i>21217</i> | | 10g. Citizen of What Country? <i>U.S.A</i> | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>NA</i> | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Welder</i> | | 16b. Kind of Business/Industry <i>General Motors</i> | | | | |
| 17. Father's Name (First, Middle, Last) <i>David Green</i> | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Lillian Murriel</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Eileen Manning Sister</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2621 Mosher Street Balto, Md 21217</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest Vet</i> | | 20c. Location - City or Town, State <i>12/13/99 Owings Mills, Md</i> | | |
| 21. Signature of Funeral Service Licensee <i>L. Ladner Warner</i> | | 22. Name and Address of Facility <i>Marple West F.H. 4300 Wabash Avenue Balto, Md 21215</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Sepsis</i> Due to (or as a consequence of): <i>b. Aspiration Pneumonia</i> Due to (or as a consequence of): <i>c. Hepatic Encephalopathy</i> Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Disseminated Intra-vascular Coagulation</i> | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier <i>Lizumi Harukuni</i> | | 29c. License number <i>89348</i> | | 29d. Date signed (Month, Day, Year) <i>12.06.99</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Lizumi Harukuni, M.D. to Maryland General Hospital</i> | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 7 1999</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38275

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lavell

Green

2. Date of Death

December 3 1999

3. Time of Death

20:15

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

197-20-6517

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03 17 28

9. Birthplace (State or Foreign Country)

West V.A.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4402 Kathland Ave

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Superior

16b. Kind of Business/Industry

Dept of Defense

17. Father's Name (First, Middle, Last)

Hovace Green

18. Mother's Name (First, Middle, Maiden Surname)

Johnnie Mae Phillips

19a. Informant's Name/Relationship (Type, Print)

Ethel O. Green-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4402 Kathland Ave, Baltimore Md 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc

20c. Location - City or Town, State

12/7/99 Baltimore Md

21. Signature of Funeral Service Licensee

▶ Gladys W. Wanner

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Intraventricular Hemorrhage

Approximate Interval Between Onset and Death

7 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature] MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

December 3 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schlosser, MD Johns Hopkins Hospital, 600 W. Wolfe St. Baltimore MD 21287

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38276

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ralph H. German | | | | 2. Date of Death Month Day Year Dec. 1. 1999 | | 3. Time of Death 12:55PM | |
| | 4a. Facility Name (If not institution, give street and number) Lorien-Riverside Nursing & Rehabilitation | | | | 4b. City, Town, or Location of Death Belcamp | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 221-10-6388 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 | | 8. Date of Birth (Month, Day, Year) Mar. 17, 1916 | |
| | 9. Birthplace (State or Foreign Country) Laurel, Delaware | | 10. Usual Residence of Decedent 10a. State Delaware | | 10b. County Sussex County | | 10c. City, Town or Location Seaford | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 719 W. Ivy Drive | | 10f. Zip Code 19973 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: U.S.A. | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warrant Officer | | 16b. Kind of Business/Industry U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last) Grover German | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Hearn | | 19a. Informant's Name/Relationship (Type, Print) William H. German (Son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 Falconer Road Joppa, MD. 21085 | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Baltimore, MD. | | 20d. Date 12/2/99 | |
| | 21. Signature of Funeral Service Licensee <i>E. F. Lassahn</i> | | 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, MD. 21087 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <i>Respiratory failure</i> Due to (or as a consequence of): b. <i>Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 day 20 years | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> | | 23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Piece of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> DO, FACEP | | 29c. License number H39022 | | 29d. Date signed (Month, Day, Year) December 2, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER LORRESTE, DO 1308 BUSINESS CENTERWAY EDGEMOND MD 21040 | | 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38277**
Certificate of Death Reg. No.

Person known as Catherine Shirley Gupton-Bey
Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Catherine Shirley Gupton-Bey | | 2. Date of Death Month Day Year NOVEMBER 30, 1999 | | 3. Time of Death 11:14 A.M. | |
| 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 216-32-7881 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth Month Day Year NOV. 12, 1935 | | 9. Birthplace (State or Foreign Country) N. Carolina | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 2717 N. Rosedale St. | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) clerk | | 16b. Kind of Business/Industry Food | |
| 17. Father's Name (First, Middle, Last) James Robinson | | | 18. Mother's Name (First, Middle, Maiden Summa) Elizabeth Green | | |
| 19a. Informant's Name/Relationship (Type, Print) Zetha Workford | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 N. Rosedale St. Balto, Md. 21216 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cemetery 12-7-99 Baltimore, Md. | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Gray-Francis Funeral Home P.A. 21220 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D0054558 | | 29d. Date signed (Month, Day, Year) November 30, 1999 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dr. Frederick Burke 2401 West Belvedere Ave Baltimore, MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature | | | |

State
Registrar

Handwritten signature

DEC 7 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38278

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE CLAIRE GORMAN

2. Date of Death

DECEMBER 2, 1999

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

220.07.9437

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

9.21.1915

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

907 ANDREWS ROAD

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

RALPH SEIGER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

NANCY D. LAMONTE

19a. Informant's Name/Relationship (Type, Print)

LYLE E. GORMAN - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

907 ANDREWS ROAD, GLEN BURNIE, MD 21060

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEM.

Date

12.6.

20c. Location - City or Town, State

CROWNSVILLE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 CRAIN HWY., SW, GLEN BURNIE, MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CANCER OF VULVA WITH METASTASIS

Approximate Interval Between Onset and Death

2-3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

SEVERE OSTEO ARTHRITIS

10 YRS. +

SEVERE ANEMIA

5 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INFECTED VULVECTOM WOUND

RADIATION CYSTITIS AND PROCTITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R. Arguillano MD

29c. License number

DR8988

29d. Date signed (Month, Day, Year)

December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Line R. Arguillano MD 3001 G. Hanover Ct. Balt. MD

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Sparks

71225

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DEC 04 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38279

| | | | | | | | | |
|---|---|---|--|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE MELVIN GALE | | | | 2. Date of Death Month Day Year DECEMBER 4, 1999 | | 3. Time of Death 4:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 1107 DEANWOOD ROAD | | | | 4b. City, Town, or Location of Death HILLENDALE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 218-42-6683 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 3/30/45 | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location HILLENDALE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1107 DEANWOOD ROAD | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 YEAR | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONTROL ENGINEER | | 16b. Kind of Business/Industry STEEL | | |
| 17. Father's Name (First, Middle, Last) REGINALD C. GALE | | | | 18. Mother's Name (First, Middle, Maiden Surname) THELMA ROBINSON | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARY B. GALE WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 DEANWOOD ROAD BALTIMORE, MD 21234 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | 20c. Date 12/7/99 | | 20d. Location - City or Town, State CATONSVILLE, MD | | |
| 21. Signature of Funeral Service Licensee <i>Heather N. Hay</i> | | | | 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Squamous Cell Carcinoma, Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 1/2 y | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Richard L. Hustig MD</i> | | | | 29c. License number D36814 | | 29d. Date signed (Month, Day, Year) 12/6/99 | | |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print) Richard L. Hustig MD 7505 OSUR DR. SUITE 302 TOWSON MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

202-358-2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38280

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GUSSIE LOU HENRY

2. Date of Death

Month Day Year
DECEMBER 03, 1999

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

5509 FERNPARK AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

219-22-3342

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 23, 1923

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5509 FERNPARK AVENUE

10f. Zip Code

21207

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

XEROX OPERATOR

16b. Kind of Business/Industry

W. R. GRACE COMPANY

17. Father's Name (First, Middle, Last)

GUS

18. Mother's Name (First, Middle, Maiden Surname)

MOLLIE

PERSONS

19a. Informant's Name/Relationship (Type, Print)

MARY BAILEY (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5509 FERNPARK AVE., BALTO. MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

12-10-99

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hyperkalemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b. renal failure

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. multiple myeloma

Due to (or as a consequence of):

5 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39639

29d. Date signed (Month, Day, Year)

12-6-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Conner Institute
Sina: Hospital 2401 W Belvidere
Baltimore 21215

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 1 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38281

| | | | | | | | | |
|--|--|---------------------------|---|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERTA OLIVIA HARP | | | | 2. Date of Death Month Day Year December 3RD, 1999 | | 3. Time of Death 1:40 AM | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL BALTIMORE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-40-4826 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 55 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT. 27, 1944 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1726 E. 28TH STREET | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING TECHNICIAN | | 16b. Kind of Business/Industry ST. JOSEPH HOSPITAL | | |
| 17. Father's Name (First, Middle, Last) CLARENCE | | | | 18. Mother's Name (First, Middle, Maiden Surname) HENSON URSULINE FENTRESS | | | | |
| 19a. Informant's Name/Relationship (Type, Print) TIA HARP-CALVIE (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3642 CHESTERFIELD AVENUE, BALTIMORE, MD. 21213 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Location - City or Town, State 12-06-99 BALTIMORE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of the Colon - Metastatic Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 5 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier H. Balfour - Darsey MD | | | | 29c. License number D0054808 | | 29d. Date signed (Month, Day, Year) December 3RD, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L.A. Balfour - Darsey, MD 504 Realm Court East, Odenton, MD 21113 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

025 7 030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38282

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte J. Hoffman

2. Date of Death

Month Day Year
DEC. 02 99

3. Time of Death

1545

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTHCARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-30-8167

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
APR 21, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2673 Wilkens Avenue

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

John B. Hoffman

18. Mother's Name (First, Middle, Maiden Surname)

Emma Yates

19a. Informant's Name/Relationship (Type, Print)

Shirley Fuller - friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3504 Buena Vista, Baltimore, Md. 21211

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

12/06/99

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 YRS.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC COLON CANCER

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

P11702

29d. Date signed (Month, Day, Year)

DEC. 02 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES C. MBONU, 900 CATON AVENUE, BALTIMORE, MD 21229

State
Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

NAME HOFFMAN, CHARLOTTE J.
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



WAVE

DEC 9 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38283

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARICE V. HARRELL

2. Date of Death
Month Day Year
DECEMBER 02 19993. Time of Death
5:30 PM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF GLEN BURNIE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL COUNTY

Funeral
Director

5. Social Security Number

212-22-4348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 28 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3310 Benson Ave. Apt. #315

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife/Domestic

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Edward Myers

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hoffnagle

19a. Informant's Name/Relationship (Type, Print)

Jean Carter (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

325 Gatewater Court Apt. 102 Glen Burnie, Md. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/06/99

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

Christina A. Milton

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

130 E. Fort ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

PREVIOUS LUNG CANCER

PREVIOUS COLON CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard E. Fisher

29c. License number

DO2519

29d. Date signed (Month, Day, Year)

12 3 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard E. Fisher Crain Towers Glen Burnie Md

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten scribbles

DEC 3 1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38284

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gary Clifford Hoyt

2. Date of Death
Month Day Year

December 03, 1999

3. Time of Death

7:40 P.M.

4a. Facility Name (If not institution, give street and number)

Business Parkway and Meadow Ridge Road

4b. City, Town, or Location of Death

Elkridge

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

215-54-7202

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 17, 1953

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Manchester

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3333 Maplegrove Rd.

10f. Zip Code

21102

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Forklift Operator

16b. Kind of Business/Industry

Giant Food

17. Father's Name (First, Middle, Last)

Homer Hoyt

18. Mother's Name (First, Middle, Maiden Surname)

Adele Bregman

19a. Informant's Name/Relationship (Type, Print)

Ayda Hoyt - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3333 Maplegrove Rd., Manchester, Md. 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hampstead Cemetery

Date

Dec. 7, 1999

20c. Location - City or Town, State

Hampstead, Md.

21. Signature of Funeral Service Licensee

Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

3296 Charmil Dr., Manchester, Md. 21102

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day Year)

12-03-1999

28b. Time of Injury

6:12 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred Subject was a driver of a motor vehicle which collided w/a vehicle.

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State) Business Parkway & Meadow Ridge Rd., Elkridge, MD

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner, M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Very sincerely yours

212-74-7000

Oct. 17, 1952

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

I am writing you regarding the

subject of the letterhead

which was received from the

Department of the Army

on October 10, 1952.

DEC 7 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38285

Amended Item#8 perFH G778 12/14/99 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Victoria L. Hatter

2. Date of Death

Dec 3rd 1999

3. Time of Death

6:09 am

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

218-46-0220

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

8-14-45
11/14/1945

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5313 LIGHTNING VIEW ROAD

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

2 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ECONOMIST

16b. Kind of Business/Industry

DEPARTMENT OF COMMERCE

17. Father's Name (First, Middle, Last)

WILLIAM J. HATTER

18. Mother's Name (First, Middle, Maiden Surname)

MARY (STANKIWICZ)

19a. Informant's Name/Relationship (Type, Print)

MARY HATTER (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5313 LIGHTNING VIEW ROAD COLUMBIA, MD 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTO. WASH. CREMATORY

Date

12/4/99 LAUREL, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Granular Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1992

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

241139

Dec 3rd, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard County Gen. Hospital, Columbia, Md.

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

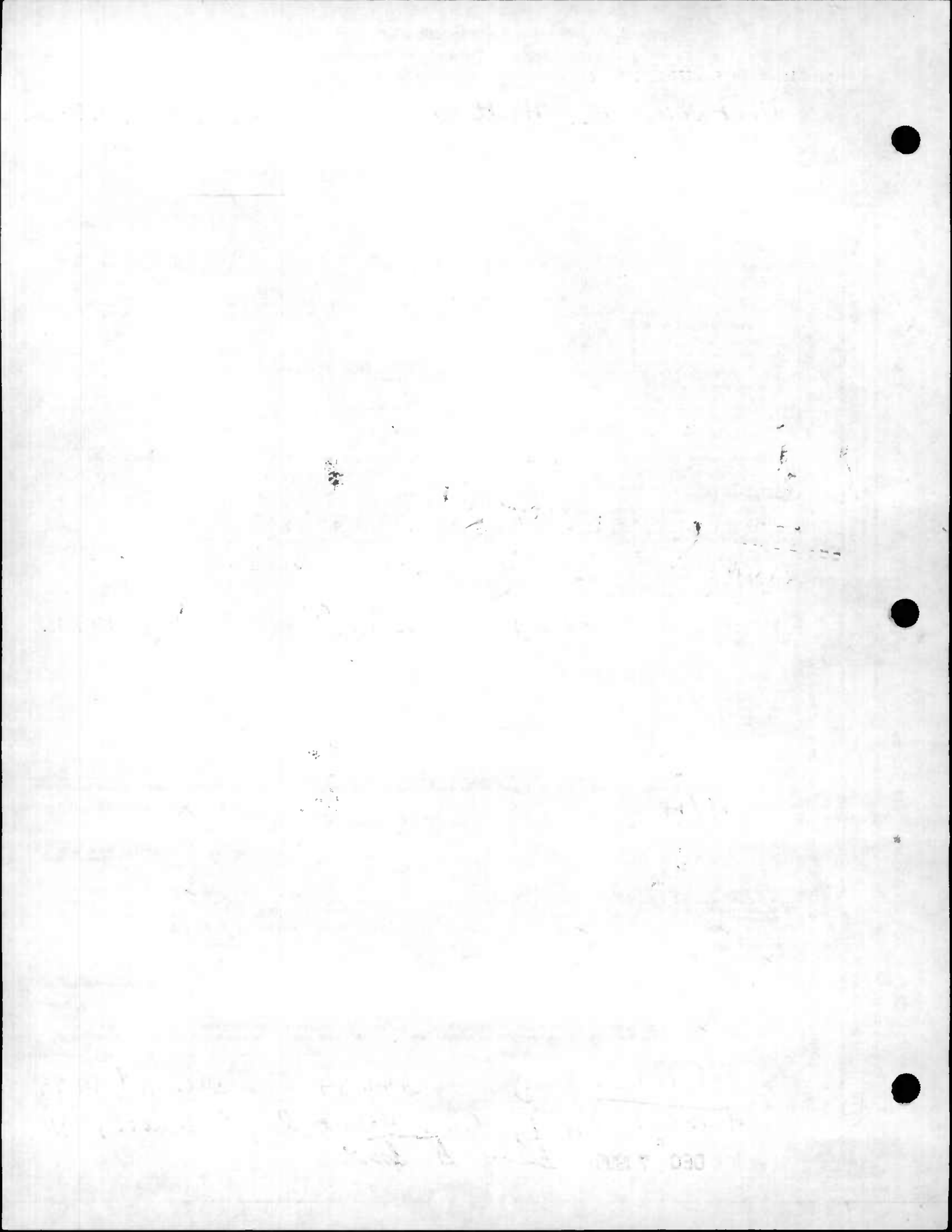
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-556-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38286

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nora Ann Hammacher

2. Date of Death

Month Day Year
Dec. 3, 1999

3. Time of Death

8:48 am

4a. Facility Name (If not institution, give street and number)

311 Trappe Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216.92.2931

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Dec. 6, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

311 Trappe Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Paul Huber

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Wolfe

19a. Informant's Name/Relationship (Type, Print)

Arlene Matulkitis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 Trappe Rd. Baltimore, Md. 21222

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore-Washington

Date

12/6/99

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home
2134 Willow Spring Rd. Balt., MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endometrial Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mos.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41490

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael McCollum, MD 9105 Franklin Square Dr., Baltimore, MD 21237

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-2000.

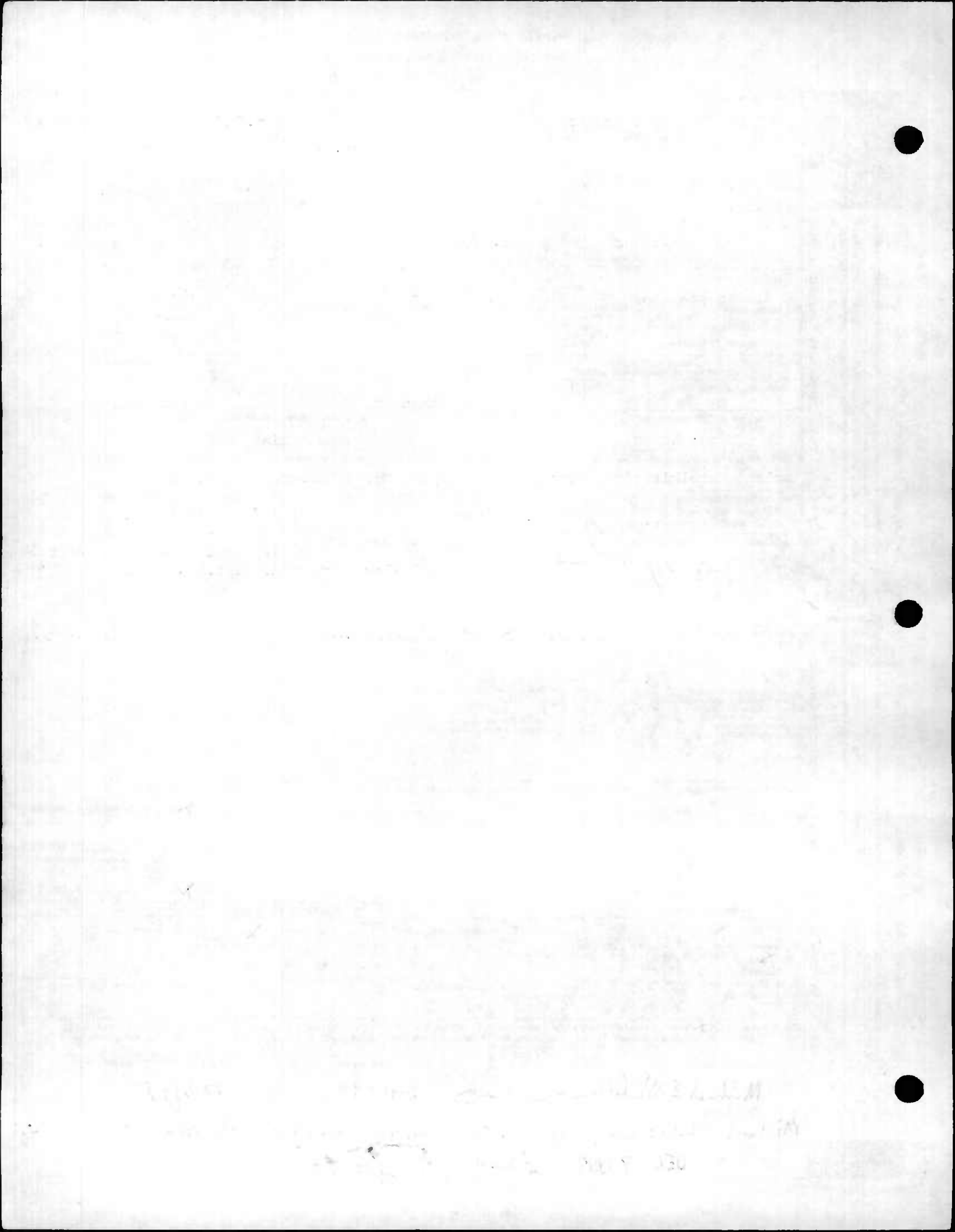
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38287

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Joseph Hresko

2. Date of Death

December 6 1999

3. Time of Death

10:30 Am

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

175-05-3012

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

07 04 1912

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

126 Rochester Place

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

John Hresko

18. Mother's Name (First, Middle, Maiden Summa)

Anna Suhar

19a. Informant's Name/Relationship (Type, Print)

Margaret Hresko/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

126 Rochester Place Balto, Md. 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn Cemetery

Date

12/9

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Moran-Ashton-Dabrowski Funeral Home, Inc
3000 E. Baltimore St. Balto, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

hours

b. Congestive heart failure

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

December 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. de Groot Johns Hopkins Bayview Medical Center Baltimore, Maryland

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38288

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Earl Heming

2. Date of Death

Month Day Year
December 5 1999

3. Time of Death

5:00 am

4a. Facility Name (If not Institution, give street and number)

530 Saltoun Avenue

4b. City, Town, or Location of Death

Odenton

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

190-30-3615

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 4, 1938

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

530 Saltoun Avenue

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1961-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Logistics Management Specialist

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

Richard E. Heming

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Lentz

19a. Informant's Name/Relationship (Type, Print)

Christopher A. Heming (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

530 Saltoun Avenue, Odenton, MD 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Epiphany Cemetery

Date

12/09

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

Nicholas P. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non Small Cell Lung

Due to (or as a consequence of):

b. Cancer - Stage IV

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mayer Goodatz MD

29c. License number

027838

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mayer Goodatz MD 785 Aqueduct Rd. Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

99 38289

DHHH 16 Rev 6/95

Handwritten signature

Handwritten signature

DEC 1 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#20b PER F.H. G778 J.A. 12-7-99

Certificate of Death

Reg. No.

99 38290

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MINNIE

HOFFMAN

2. Date of Death

November 25, 1999

3. Time of Death

12:35 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-26-9840

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 13, 1930

9. Birthplace (State or Foreign)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

BALTO. CO.

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3404 OLD POST DRIVE

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

REAL ESTATE AGENT

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

BENJAMIN

INGBER

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA

LICHTER

19a. Informant's Name/Relationship (Type, Print)

STANLEY HOFFMAN /HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3404 OLD POST DRIVE BALTO., MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

- SWINICHER BENEVOLENT

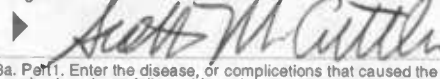
Date

11/28/99

20c. Location - City or Town, State

BALTO, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOL LEVINSON BROS., INC.
8900 REISTERSTOWN ROAD BALTO., MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Sepsis

e.

Due to (or as a consequence of):

Aspiration pneumonia

b.

Due to (or as a consequence of):

Acute myocardial infarction

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

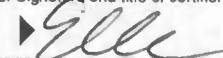
M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D0053965

29d. Date signed (Month, Day, Year)

November 26, 1999

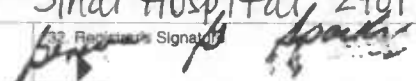
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellie Cohen, MD Sinai Hospital 2401 W. Belvedere Avenue Balto MD 21215

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature


State
Registrar

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Patient Known As: Minnie Hoffman
Baltimore, Maryland 21215-0020

A1-4

Original from [illegible]

DEC 1 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38291

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NETTIE V. HENLINE

2. Date of Death

Month Day Year

DEC. 2, 1999

3. Time of Death

6:30 A.M.

4a. Facility Name (If not Institution, give street and number)

Manor Care Towon

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

234-46-4911

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6/10/04

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1614 YAKONA ROAD

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7TH GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GILBERT LOUGH

18. Mother's Name (First, Middle, Maiden Summa)

EISEBELL WAVE

19a. Informant's Name/Relationship (Type, Print)

BONNIE CLEVINGER

DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1614 YAKONA ROAD TOWSON, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LONG POINT CEMETERY

Date

12/5/99

20c. Location - City or Town, State

WALKERSVILLE, WV

21. Signature of Funeral Service Licensee

Heather N. Hays

22. Name and Address of Facility

JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

b.

Cerebrovascular disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Days weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiac Ischemia

J. 2000

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Heather N. Hays

29c. License number

D08358

29d. Date signed (Month, Day, Year)

12/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8903 HARTFORD ROAD BALTIMORE, MD 21234

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

*B. Spots*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38292

| | | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RALPH N. HYLTON | | | | 2. Date of Death Month Day Year December 5, 1999 | | | | 3. Time of Death 11:07AM | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 302-26-3563 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 15, 1935 | | 9. Birthplace (State or Foreign Country) KENTUCKY | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1033 SHORELAND DRIVE | | | | 10f. Zip Code 21060 | | | | 10g. Citizen of What Country? UNITED STATES | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST | | | | 16b. Kind of Business/Industry MANUFACTURING | | |
| 17. Father's Name (First, Middle, Last) CHARLES HYLTON | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MONNIE M. BERRY | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELIZABETH J. HYLTON/ WIFE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1033 SHORELAND DRIVE, GLEN BURNIE, MD 21060 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | Date DEC. 9 1999 | | 20c. Location - City or Town, State BROOKLYN PARK, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus. | | | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier House Staff | | | | | 29c. License number D51596 | | 29d. Date signed (Month, Day, Year) December 5th 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Ambalavanar, North Arundel Hospital, 301 Hospital Drive, Glen Burnie MD 21061 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38293

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STELLA M. HARRY

2. Date of Death

December 4, 1999

3. Time of Death

7:10 AM

4a. Facility Name (If not institution, give street and number)

Dulaney, Towson Nursing Home

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-10-3886

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 12, 1923

9. Birthplace (State or Foreign Country)

P.A.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 NOT MAG Knoll CT.

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Book keeper

16b. Kind of Business/Industry

own Business

17. Father's Name (First, Middle, Last)

Norman Beers

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Stevens

19a. Informant's Name/Relationship (Type, Print)

HILDA M. COOK (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 NOT MAG Knoll CT. Cockeysville, MD 21030

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH cemetery

Date

12/7/99

20c. Location - City or Town, State

Rosedale, MD

21. Signature of Funeral Service Licensee

Paul M. Stella

22. Name and Address of Facility

HARTLEY Miller Funeral Home CHFD.

7527 HARford RD. BALTO MD 21234

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive heart Failure

Approximate Interval Between Onset and Death

6 months

Due to (or as a consequence of):

Coronary Artery Disease

10 years

Due to (or as a consequence of):

Chronic Renal failure

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

X/AO M2H04 Attending Physician

29c. License number

D53642

29d. Date signed (Month, Day, Year)

Dec 5, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

X/AO M2H04 3007 E Northern Parkway Baltimore 21214

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 9 1989

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38294

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph George Imhoff

2. Date of Death

Month

Day

Year

DECEMBER 4, 1999

3. Time of Death

1:03 P.M.

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-20-1997

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov 9, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8617 Goldenwood Road

10f. Zip Code

21237

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Metallurgist

16b. Kind of Business/Industry

Bethlehem Steel Co.

17. Father's Name (First, Middle, Last)

Paul H. Imhoff

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle

(Not Known)

19a. Informant's Name/Relationship (Type, Print)

Alice V. Imhoff (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8617 Goldenwood Rd. Baltimore, Maryland 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans

Date

12/9/99

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Milton J. Knight Jr

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METABOLIC ACIDOSIS

Due to (or as a consequence of):

b. ACUTE RENAL FAILURE

Due to (or as a consequence of):

c. OBSTRUCTIVE NEPHROPATHY

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, STATUS POST COLECTOMY FOR COLON CANCER, ACUTE MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rachel Bern

29c. License number

R.D. #198994

29d. Date signed (Month, Day, Year)

12/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RACHEL BERN 9000 FRANKLIN SQUARE DR. BALTO, MD 21237

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Geneva S. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 37 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

IMHOFF JOSEPH
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38295

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHERRY RAY SENTER

2. Date of Death
Month Day Year

November 27, 1999

3. Time of Death

12:20 PM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital 5401 Old Central Rd 21133

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore, Maryland

Funeral
Director

5. Social Security Number

219-88-4676

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

37

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

JULY 2 1962

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 FITZ COURT APT. T-3

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

GEORGE

SENER

18. Mother's Name (First, Middle, Maiden Surname)

MAUREEN

WHITEHAIR

19a. Informant's Name/Relationship (Type, Print)

MAUREEN SENTER/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 FITZ CT. APT. T-3 REISTERSTOWN, MD. 21136

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FOREST LAWN CEMETERY

Date

11/29/99

20c. Location - City or Town, State

NORFOLK, VA.

21. Signature of Funeral Service Licensee

Scott M. Cottle

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic encephalopathy

Due to (or as a consequence of):

b. Sustained Seizures

Due to (or as a consequence of):

c. Lemax Gastant Syndrome

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Scott M. Cottle MD.

29c. License number

D37035 - MD

29d. Date signed (Month, Day, Year)

11-27-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann LEFKOWITZ, MD 3527 Rolling Road, Suite 4 Baltimore, MD 21044

State
Registrar

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Benjamin B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1
Date: 12/1/1999
Time: 10:00 AM

Subject: [Illegible]
[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38296

Amended Item#23,23b perPhyG778 12/10/99 EW

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Leonard G. Johnson | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 6:00AM | |
| | 4a. Facility Name (If not institution, give street and number) Gilchrist Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217-03-9429 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 23, 1918 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Parkton | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1915 Mt. Carmel Road | | | | 10f. Zip Code 21120 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steamfitter | | 16b. Kind of Business/Industry Plumbing | | |
| 17. Father's Name (First, Middle, Last) Charles W. Johnson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Howard | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carol L. Johnson/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 Mt. Carmel Road Parkton, MD 21120 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crematory | | Date Dec. 7, 1999 | | 20c. Location - City or Town, State Laurel, MD | | |
| 21. Signature of Funeral Service Representative  Michael J. Flagle | | | | 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung cancer a. Due to (or as a consequence of): ASBESTOSIS b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  W.A. Riley | | | | 29c. License number 025205 | | 29d. Date signed (Month, Day, Year) December 4, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GMC 6701 N. Charles St. Balto. md 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature  | | | | | | |

12/10/50
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12/10/50

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#5 PER F.H. G778 12-7-99 J.A.

Certificate of Death

Reg. No.

99 38297

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOE S. JOYNER

2. Date of Death

December 1, 1999

3. Time of Death

6:17 AM

4a. Facility Name (If not institution, give street and number)

FAUSTON General Hospital

4b. City, Town, or Location of Death

FAUSTON, MD

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

249-03-7935

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

09/23/13

10. Inside City Limits

1 ☐ Yes 2 ☒ No

Usual Residence of Decedent

10a. State

SC

10b. County

HAMPTON

10c. City, Town or Location

VARNVILLE

10e. Street and Number

RURAL RT 1 BOX 46A
SYLVESTER MOLE ROAD

10f. Zip Code

29944

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

DRY CLEANERS

17. Father's Name (First, Middle, Last)

SMART JOYNER

18. Mother's Name (First, Middle, Maiden Surname)

ELLA

19a. Informant's Name/Relationship (Type, Print)

EARL JOYNER BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 FORREST CIRCLE, ALLENDALE, SC 29810

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

6 FORREST CIRCLE, 1

Date

12-6-99

20c. Location - City or Town, State

VARNVILLE, SC

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALD. NATL PIKE, BALD. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MI

Due to (or as a consequence of):

b. END STAGE RENAL DISEASE

Due to (or as a consequence of):

c. HTN

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 hrs

5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vaughn C. Greene

29c. License number

D23396

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARILYN S. MACVEY, FAUSTON General Hospital, FAUSTON, MD

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 3035.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature

DEC 0 7 1902

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38298

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HERBERT L.

2. Date of Death

Month Day Year
DECEMBER 4 1999

3. Time of Death

5:55 AM

4a. Facility Name (If not institution, give street and number)

JOHN HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

229-18-0819

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 15 1921

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

ABERDEEN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

916 S. STEPNEY ROAD

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 61/62

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12yrs

College (1-4 or 5+)

2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TECH WRITER

16b. Kind of Business/Industry

US ARMY
FED CIVIL SERVICE

17. Father's Name (First, Middle, Last)

LETCHER LINCOLN JOINER

18. Mother's Name (First, Middle, Maiden Summa)

MYTLE HASH JOINER

19a. Informant's Name/Relationship (Type, Print)

Mamie L. Joiner/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

916 S STEPNEY ROAD, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARFORD MEMORIAL GARDENS

Date

12-6-99

20c. Location - City or Town, State

ABERDEEN, MARYLAND

21. Signature of Funeral Service Licensee

Barbara A. Brown

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
321 S. PHILADELPHIA BLVD., ABERDEEN, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GLOBAL TISSUE ISCHEMIA

Approximate Interval Between Onset and Death

3 DAYS

Due to (or as a consequence of):

b. ACUTE BLOOD LOSS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Lofwall MD CORMACK

29c. License number

AF 2664200 L245

29d. Date signed (Month, Day, Year)

DECEMBER 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Lofwall JOHN HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-697-2000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 3 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38299

Certificate of Death

Reg. No.

AMENDED ITEM #20b PER FH G778 12/29/99 AH

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-695-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Mary Ann Jacobin | | 2. Date of Death Month December Day 5 Year 1999 | | 3. Time of Death 9:45 PM | |
| 4a. Facility Name (If not institution, give street and number) 11211 Lilac Lane | | | 4b. City, Town, or Location of Death Perry Hall | | 4c. County of Death Baltimore |
| 5. Social Security Number 233-42-8630 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 2, 1922 |
| 9. Birthplace (State or Foreign Country) West Virginia | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Perry Hall | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 11211 Lilac Lane | | | 10f. Zip Code 21128 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) College | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home |
| 17. Father's Name (First, Middle, Last) Frank Trovato | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Mike | | |
| 19a. Informant's Name/Relationship (Type, Print) Lynn Doty (daughter) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11154 Philadelphia Rd., White Marsh, MD 21162 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee Brian A. Wellen | | | 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. Depression Due to (or as a consequence of): | | | | | |
| b. UTI - urinary tract infection Due to (or as a consequence of): | | | | | |
| c. Alzheimer's Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 044560 | | 29d. Date signed (Month, Day, Year) 12/6/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFF ALEXANDER 10755 FALLS RD SUITE 460 LUTHERVILLE MD 21093 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature [Signature] | | | |

State
Registrar

James H. Jones

DEC 07 1909

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38300

| | | | | | | | | | | |
|---|---|--------------------|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SARAH FRANCES JOHNSON | | | | | | 2. Date of Death Month Day Year DEC. 2, 1999 | | 3. Time of Death 7:30pm | |
| | 4a. Facility Name (If not institution, give street and number) 3411 MILFORD AVENUE | | | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 231-28-2424 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 28 1921 | | 9. Birthplace (State or Foreign Country) VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 3411 MILFORD AVENUE | | | | | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RETAIL | | | | 16b. Kind of Business/Industry CLOTHING | | |
| 17. Father's Name (First, Middle, Last) JOHN HENRY HARROD | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELLEN ANN WHITAKER | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Thomas O. Wilmore/Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6408 Laurel Drive, Baltimore, Maryland 21207 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | Date 12-7-99 | | 20c. Location - City or Town, State WOODLAWN, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee <i>Barbara H. Brown</i> | | | | 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pulmonary Hypertension</u> Due to (or as a consequence of): b. <u>Congestive Heart Failure</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death 12wks 2wks | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Carlos S. Ince, Jr. MD</i> | | | | 29c. License number D0054175 | | | 29d. Date signed (Month, Day, Year) 12/6/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlos S. Ince, Jr. 3449 Wilkens Ave, Suite 300 Baltimore, MD 21229 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

DEC 7 1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38301

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) MILDRED KRAFT | | | | 2. Date of Death Month NOV. Day 22 Year 1999 | | 3. Time of Death 5:00 A.M. | |
| 4a. Facility Name (If not institution, give street and number) FUTURE CARE HOMEWOOD | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 705 05 2031 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 13, 1905 | |
| 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2700 N. CHARLES ST. | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler | | 16b. Kind of Business/Industry Manufacturing | | 17. Father's Name (First, Middle, Last) John Bruchey | |
| 18. Mother's Name (First, Middle, Maiden Surname) Ella/Unknown | | 19a. Informant's Name/Relationship (Type, Print) Alisa Cobrinetz, Atty. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Light St., St. 403, Baltimore, Md. 21202 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) London Park Cemetery | | 20c. Date 11/26/99 | | 20d. Location - City or Town, State Baltimore, MD. | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility Gary L. Kaufman F.H. @ Meadowridge Mem. Pk., Inc. 7250 Washington Blvd., Elkridge, MD 21075 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE. YEARS Due to (or as a consequence of): b. ATRIAL FIBILLATION YEARS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA ; DEPRESSION ; DEMENTIA COMPRESSION FRACTURES | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D52360 | | 29d. Date signed (Month, Day, Year) 11/23/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1838 GREENE TREE RD SUITE 300 PICESVILLE MD 21208 | | 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38302

| | | | | | | | | | | | |
|--|---|---------------------------|---|---|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD W. KNOTT, SR. | | | | 2. Date of Death Month Day Year December 6 1999 | | | | 3. Time of Death 12:10 AM | | |
| | 4e. Facility Name (If not institution, give street and number) Mercy Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 213 - 34 - 2523 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) November 8, 1936 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 40 East Cross Street | | | | 10f. Zip Code 21230 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | | | 16b. Kind of Business/Industry Baltimore Public Market Corp. | | | |
| 17. Father's Name (First, Middle, Last) John Howard Knott, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Amelia Krebs | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Evelyn Knott (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 East Cross Street, Baltimore, Md. 21230 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park | | | 20c. Location - City or Town, State 12/09/99 Glen Burnie, Md. | | | | | |
| 21. Signature of Funeral Service Licensee Christina L. Hilton | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Lung CANCER Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death 2 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how Injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Dina Deutsch MD | | | | | | | |
| | | | | 29c. License number P 13372 | | | | 29d. Date signed (Month, Day, Year) December 6, 1999 | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Mercy Medical Center 301 St Paul Baltimore, Maryland | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-586-0050.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT
5301 S. DICKINSON AVE.
CHICAGO, ILL. 60637

Dear Sirs:

I am writing to you regarding the results of the experiment performed on the 15th of May, 1968. The results are as follows:

The first part of the experiment was a test of the hypothesis that the rate of decay of a certain substance is proportional to the square of the initial concentration. The results of this test are shown in the table below:

| Initial Concentration (M) | Rate of Decay (M/s) |
|---------------------------|---------------------|
| 0.1 | 0.01 |
| 0.2 | 0.04 |
| 0.3 | 0.09 |
| 0.4 | 0.16 |
| 0.5 | 0.25 |

The second part of the experiment was a test of the hypothesis that the rate of decay of a certain substance is proportional to the initial concentration. The results of this test are shown in the table below:

| Initial Concentration (M) | Rate of Decay (M/s) |
|---------------------------|---------------------|
| 0.1 | 0.01 |
| 0.2 | 0.02 |
| 0.3 | 0.03 |
| 0.4 | 0.04 |
| 0.5 | 0.05 |

The results of the first part of the experiment are in good agreement with the hypothesis that the rate of decay is proportional to the square of the initial concentration. The results of the second part of the experiment are in good agreement with the hypothesis that the rate of decay is proportional to the initial concentration.

I am sure that these results will be of interest to you. I am sure that you will find them very interesting.

Very truly yours,

John Doe
150 7 331

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38303

AMEND#7 PER F.H. G778 12-7-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mikhail Kostovetsky

2. Date of Death

Month

Day

Year

12

1

1999

3. Time of Death

8:00 A.M.

4a. Facility Name (If not institution, give street and number)

3601 Fords Lane Apt. 701

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-11-2755

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

7/1/1915

9. Birthplace (State or Foreign Country)

Ukraine

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3601 Fords La.

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Vasily Kostovetsky

18. Mother's Name (First, Middle, Maiden Surname)

Dina Unknown

19a. Informant's Name/Relationship (Type, Print)

Manya Kostovetsky/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3601 Fords La. Apt. 701 Baltimore, MD 21215

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore/Washington Crematory

Date

12/2/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge Memorial Park 7250 Washington Blvd. Elkridge, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 20158

29d. Date signed (Month, Day, Year)

12-01-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. A. FRAYHA M.D. 3640 Fords Lane BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

DEC 9 1 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38304

| | | | | | | | | | | |
|--|---|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANCES WANDA KOPERA | | | | 2. Date of Death Month Day Year DECEMBER 04 1999 | | | | 3. Time of Death 2:40 PM | |
| | 4a. Facility Name (If not institution, give street and number) STELLA MARIS NURSING HOME | | | | 4b. City, Town, or Location of Death TOWSON | | | | 4c. County of Death BALTIMORE COUNTY | |
| Funeral Director | 5. Social Security Number 213-12-8079 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) April 18 1921 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | 10b. County Howard County | | 10c. City, Town or Location Clarksville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 11506 Blueflame Court | | 10f. Zip Code 21029 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dispatcher | | | 16b. Kind of Business/Industry Locke Insulator | | | | |
| | 17. Father's Name (First, Middle, Last) Konstantin Aleksalza | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Mary Malinovoska | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Anthony Kopera (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11506 Blueflame Court, Clarksville, Md. 21029 | | | | | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery | | Date 12/07/99 | | 20c. Location - City or Town, State Brooklyn Park, Md. | | | |
| | 21. Signature of Funeral Service Licensee <i>Christina A. Walton</i> | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic coronary artery disease</i> Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>Miriam Kowalcuska MD</i> | | | | 29c. License number D21022 | | 29d. Date signed (Month, Day, Year) 12-6-99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>M. Kowalcuska 8114 SANDPIPER CIRCLE MD 21236</i> | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature <i>James B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or name, located in the middle of the page.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38305

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frieda Kraska

2. Date of Death

Month Day Year
Dec. 4, 1999

3. Time of Death

1:20 pm

4a. Facility Name (If not institution, give street and number)

3514 Wild Cherry Road

4b. City, Town, or Location of Death

Woodlawn

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

098-34-7656

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/6/1928

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

X

10e. Street and Number

3514 Wild Cherry Road

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ludwig Kramer

18. Mother's Name (First, Middle, Maiden Surname)

Anna Maria Zorgiebel

19a. Informant's Name/Relationship (Type, Print)

Werner Preibisch/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3514 Wild Cherry Rd. Woodlawn Md 21244

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balto-Washington

Date

12/7

20c. Location - City or Town, State

Laurel, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Road, Balto, Md 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Endometrial Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

17 Months

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46118

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1447 York Rd Lutherville MD 21093

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Page 101

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38306

| | | | | | | | | | | |
|---|---|---------------------------------|---|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert E. Lynch | | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 11:15 am | | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 216-10-9772 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 6, 1914 | | 9. Birthplace (State or Foreign Country) MD. | |
| | Usual Residence of Decedent | | | | | 10c. City, Town or Location | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10a. State MD. | | 10b. County BALTIMORE | | 10c. City, Town or Location DUNDALK | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 8225 LONGPOINT ROAD. | | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUS DRIVER | | | 16b. Kind of Business/Industry M.T.A. MASS TRANSIT | | |
| 17. Father's Name (First, Middle, Last) JOHN VALENTINE LYNCH | | | | | 18. Mother's Name (First, Middle, Maiden Summa) ANNIE D. BECKER | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERT E LYNCH JR/son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 GRIZZLY BEAR PATH ORMOND BEACH, FLA 32174 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | | 20c. Location - City or Town, State BALTO. MD. | | 20d. Date 12/6/99 | | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | | | | 22. Name and Address of Facility CONNELLY Funeral Home of Dundalk 7110 Sellers Point RD. BALTO MD 21222 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Pulmonary Emboli Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Chronic Obstructive Pulmonary Disease | | | | | | | | | Approximate Interval Between Onset and Death 6 hours 1 hour | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier Alan M. Weiss - Resident Physician | | | 29c. License number 98033 | | 29d. Date signed (Month, Day, Year) December 4, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan M. Weiss MD, 4940 Eastern Ave, Baltimore, MD 21224 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | 32. Registrar's Signature [Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

James H. Brown

DEC 8 1923

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38307

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor H. Luedtke

2. Date of Death

Month Day Year
DECEMBER 02 1999

3. Time of Death

5:55 PM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD COUNTY

Funeral
Director

5. Social Security Number

219-20-9032

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9/20/10

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7835 Americana Circle

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edmund Telewicz

18. Mother's Name (First, Middle, Maiden Surname)

Marian Goetz

19a. Informant's Name/Relationship (Type, Print)

Margaret Konopka (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 Pheasant Dr. Forest Hill MD., 21050

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

12/6/99

20c. Location - City or Town, State

Balto., MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

3204 Mountain Road Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

coronary artery disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

22 years

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32273

29d. Date signed (Month, Day, Year)

December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Dunn 615 W. MacPhail Rd. Bel Air, MD 21014

State
Registrar

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

DEC 3 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38308

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Dennis L. Ladd | | | | 2. Date of Death Month 12 Day 2 Year 99 | | 3. Time of Death 8:52A | |
| 4a. Facility Name (If not Institution, give street and number) University of Maryland Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore City | |
| 5. Social Security Number 217 66 6329 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 45 Yrs. | | 8. Date of Birth (Month, Day, Year) 6/30/54 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | Usual Residence of Decedent | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2405 Maryland Avenue | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Dairy | |
| 17. Father's Name (First, Middle, Last) Raymond R. Ladd | | | | 18. Mother's Name (First, Middle, Maiden Surname) Myrtle A. Englehardt | | | |
| 19a. Informant's Name/Relationship (Type, Print) John Ladd Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 W. 27th Street, Baltimore, Maryland 21211 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Baltimore-Washington | | 20c. Date 12/3/99 | | 20d. Location - City or Town, State Laurel, Maryland | |
| 21. Signature of Funeral Service Licensed  | | | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  MD | | 29c. License number P12487 | | 29d. Date signed (Month, Day, Year) 12/2/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig Skinner MD, Univ. of Maryland Hosp. | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature  | | | | | |

AH

DEC 0 3 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38309

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wanda Labesky

2. Date of Death
Month Day Year
12 04 993. Time of Death
7:00 PM

4a. Facility Name (If not institution, give street and number)

Ridgeway Manor Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

046-03-1335

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Nov. 26, 1911

9. Birthplace (State or Foreign
Country)

Mass.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

7114 Upper Mills Circle

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Kolenda

18. Mother's Name (First, Middle, Maiden Surname)

Kastancya (Kvaraciejate)

19a. Informant's Name/Relationship (Type, Print)

Anthony Labesky (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7114 Upper Mills Circle, Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. St. Benedict

Date

12/9/99

20c. Location - City or Town, State

Hartford Connecticut

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Coronary Vascular Disease year

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

degenerative osteoarthritis, schizophrenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael H. Schwartz

29c. License number

D18667

29d. Date signed (Month, Day, Year)

12-5-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL H. SCHWARTZ, 5512-ARITCHEE HIGHWAY BALTO, MD 21228

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

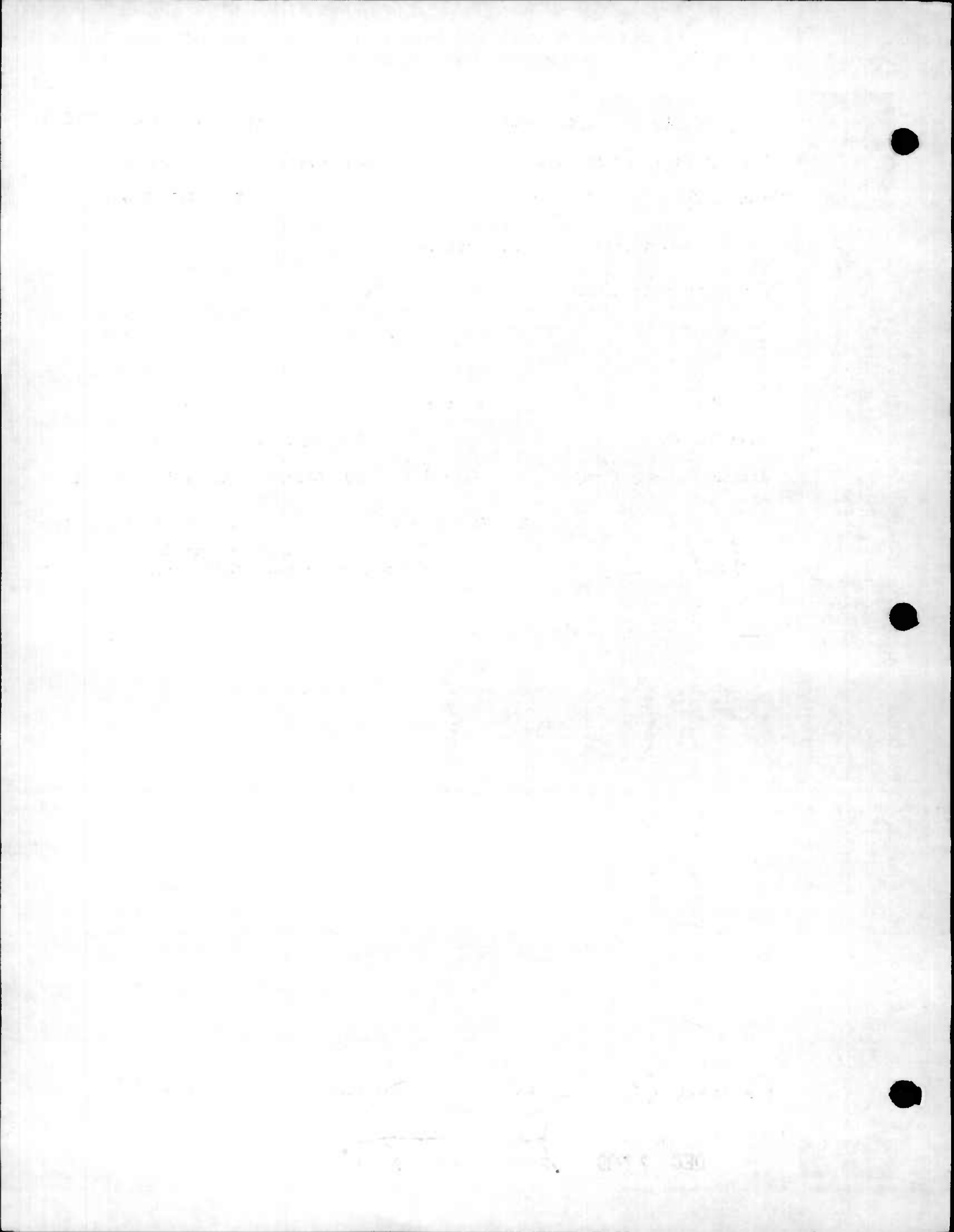
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38310

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Clara E. Lindeman | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 6:10 PM | |
| | 4a. Facility Name (If not institution, give street and number) Maryland Masonic Homes | | | | 4b. City, Town, or Location of Death Cockeysville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-14-1765 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) June 17, 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Cockeysville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 300 International Cir. | | 10f. Zip Code 21030 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) William Henry Fowler | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Sophia Helgaman | | | | 19a. Informant's Name/Relationship (Type, Print) Donna Stifler/Granddaughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Kreidler Valley Road Forest Hill, MD 21050 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery | | 20c. Date Dec. 7, 1999 | | 20d. Location - City or Town, State Baltimore, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Director Michael J. Flagle | | | | 22. Name and Address of Facility Lemmon Funeral Home of Dulany valley, Inc. 10 W. Padonia Road Timonium, MD 21093 | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Atherosclerotic Vascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, Dementia, | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier R. Lentz, M.D. | | | |
| | 29c. License number D21464 | | | | 29d. Date signed (Month, Day, Year) 12-6-99 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Liberto, M.D. 3508 Bank Street Baltimore, MD 21224 | | | | 31. Date filed (Month, Day, Year) DEC 7 1999 | | | |
| | 32. Registrar's Signature [Signature] | | | | 33. Registrar's Signature [Signature] | | | |

ORIGINAL

Handwritten signature or initials.

DEC 1 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38311

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHEA M. LEE

2. Date of Death

Month

Day

Year

December 5 1999

3. Time of Death

4:23AM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS AT MERCY

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-09-9443

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10-31-19

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4800 YELLOWWOOD AVE.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

POSTAL CLERK

16b. Kind of Business/Industry

US POST OFFICE

17. Father's Name (First, Middle, Last)

GEORGE LEE

18. Mother's Name (First, Middle, Maiden Surname)

VIOLA KESS

19a. Informant's Name/Relationship (Type, Print)

MIRIAM DIXON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6414 WOODGREEN CIR., BALTO. MD. 21207

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

12-11-99

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Thompson

29c. License number

D40854

29d. Date signed (Month, Day, Year)

12/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Fischer 301 St Paul Pl Baltimore 21202

State
Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Benjamin D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Handwritten signature

DEC 9 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38312

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEANNE AGNES LAMB

2. Date of Death

December 04, 1999

3. Time of Death

8:10 A.M.

4a. Facility Name (If not institution, give street and number)

3513 Juneway, 2nd Floor Apartment

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-18-7967

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

6/1/24

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3513 JUNEWAY 2ND FLR

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

OFFICE

17. Father's Name (First, Middle, Last)

THOMAS E. LAMB

18. Mother's Name (First, Middle, Maiden Surname)

THERESE FEEHLEY

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH TAYLOR

SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8676 OAK ROAD BALTIMORE, MD 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH CEM.

Date

12/7/99

20c. Location - City or Town, State

PARKVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

Inspection

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 05, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KANE

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Genevieve B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38313

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEE W

MARK EY

2. Date of Death

Month Day Year
DEC 4 1999

3. Time of Death

3 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ICU FALLSTON GEN HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

5. Social Security Number

185-28-1942

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 20, 1938

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

JOPPA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

233 GARNETT ROAD

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

GENERAL CONTRACTOR

17. Father's Name (First, Middle, Last)

JOHN W. MARKEY

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE C. AUGENBAUGH

19a. Informant's Name/Relationship (Type, Print)

BARBARA MARKEY, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

233 GARNETT RD. JOPPA, MD. 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUSQUEHANNA MEM. GDS.

Date

DEC. 8, 1999

20c. Location - City or Town, State

YORK, PA

21. Signature of Funeral Service Licensee

Chad C. Amato

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
2325 YORK RD. TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. A W I E MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERGLYCAEMIA

HYPERCHOLESTEROLEMIA.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DEC 4 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G PRABHU MD 218 Guilford AVE BELAIR MD 21014

State
Registrar

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

S. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38314
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|---|--|---|--|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rose Maggio | | | | 2. Date of Death Month Dec Day 4 Year 1999 | | | | 3. Time of Death 12:10 pm | | |
| | 4a. Facility Name (If not institution, give street and number) 8521 Fowler Ave | | | | 4b. City, Town, or Location of Death Parkville | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 215-07-5725 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan 31, 1911 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | | | 10b. County Baltimore | | 10c. City, Town or Location Parkville |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 8521 Fowler Ave. | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) office worker | | | | 16b. Kind of Business/Industry Stewart & Com. | | |
| | 17. Father's Name (First, Middle, Last) Joseph Maggio | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marianna D'Amico | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Christine Hemminger | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6068 Green Meadow Pkwy Balto. Md 21209 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Come. | | Date Dec 9 1999 | | 20c. Location - City or Town, State Baltimore, Md. | | | | |
| | 21. Signature of Funeral Service Licensee Kevin S. Wells | | | | 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234 | | | | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. HCV Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Fausto Q. Aguirre, MD | | 29c. License number D14697 | | 29d. Date signed (Month, Day, Year) 12-06-99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Fausto Aguirre 8713 Harford Rd Baltimore, Md 21234 | | | | 31. Data filed (Month, Day, Year) DEC 7 1999 | | | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



THE NATIONAL BUREAU OF STANDARDS
WASHINGTON, D. C. 20540
U. S. DEPARTMENT OF COMMERCE

B.K.S

AMEND ITEMS: #10F PER F.H.

State of Maryland / Department of Health and Mental Hygiene

UNKNOWN 99-296 Devon Mayfield

Certificate of Death

Reg. No.

99 38315

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-2222.

Division of Vital Records, P.O. Box 68760,

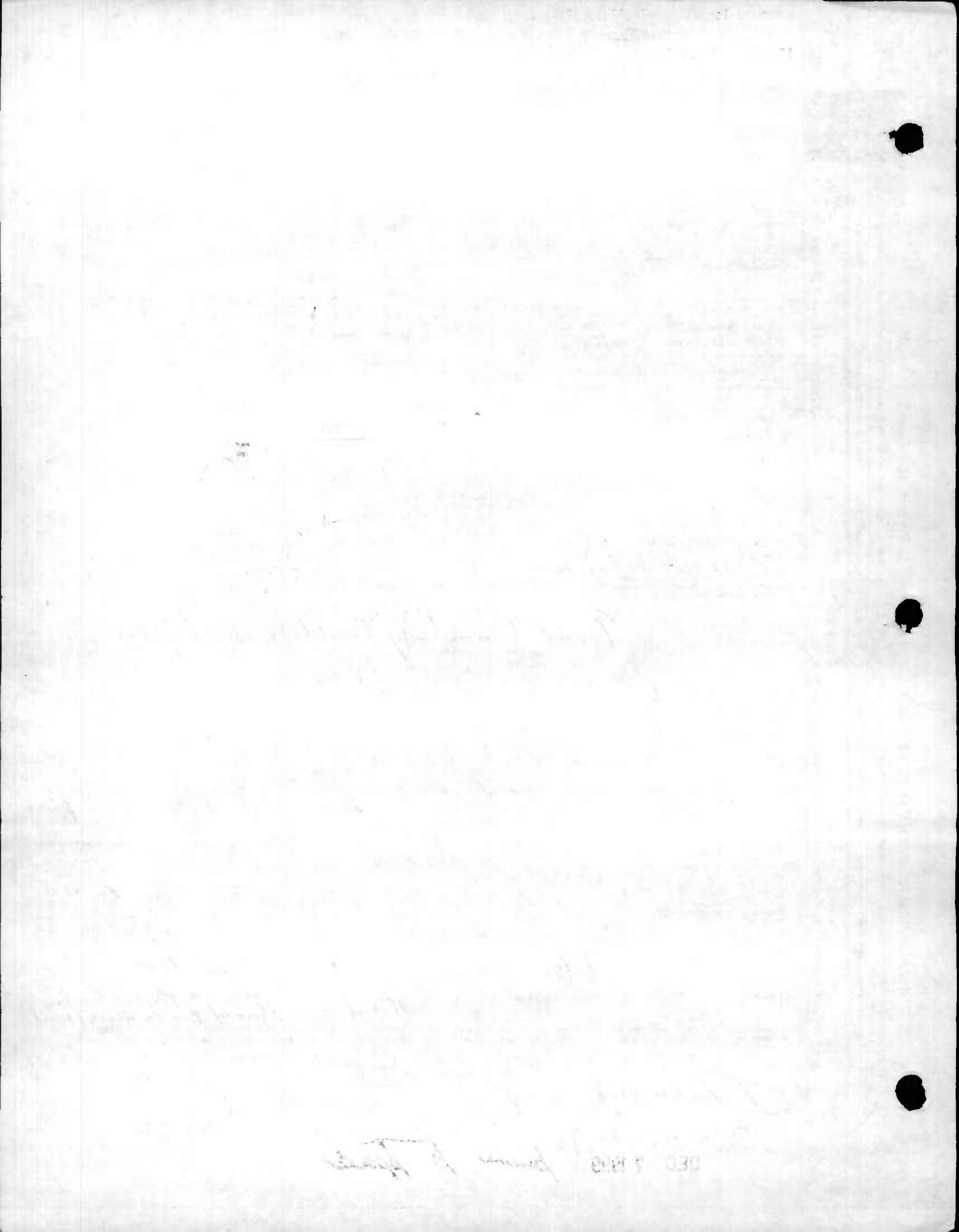
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Davon L. Mayfield | | 2. Date of Death Month Day Year NOV. 29, 1999 | | 3. Time of Death 4:50 PM | |
| 4a. Facility Name (If not institution, give street and number) REAR OF 5780 STEVENS FORREST ROAD | | | 4b. City, Town, or Location of Death COLUMBIA | | 4c. County of Death HOWARD |
| 5. Social Security Number 216-98-3789 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 18 Yrs. | 8. Date of Birth (Month, Day, Year) 4-21-1981 | 9. Birthplace (State or Foreign Country) Md | |
| Usual Residence of Decedent | | | | | |
| 10a. State Md | 10b. County Howard | 10c. City, Town or Location Columbia | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7181 Peach Chimes Ct | | 10f. Zip Code 21045 | | 10g. Citizen of What Country? U S A | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed | | 16b. Kind of Business/Industry Roofing | |
| 17. Father's Name (First, Middle, Last) William L. Mayfield, Sr | | 18. Mother's Name (First, Middle, Maiden Surname) Cynthia Little | | | |
| 19a. Informant's Name/Relationship (Type, Print) Cynthia Little - Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7181 Peach Chimes Court Columbia, Md 21045 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State Randallstown, Md | |
| 21. Signature of Funeral Service Licensee <i>Shannon Stokes</i> | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Punctured Wounds (2) of Chest (1) and Thigh (1)</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 11/6/99 | | 28b. Time of Injury 4:25 pm M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <i>Subject shot</i> | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>street</i> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Forest Road in Howard County Maryland</i> | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Theresa McKing</i> | | | | | |
| 29b. Signature and title of certifier <i>Theresa McKing</i> | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 30, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Theodore McKing</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature <i>Benjamin B Sparks</i> | | | |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38316

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILA MAE MCCLAIN

2. Date of Death

Month Day Year
DEC. 02 1999

3. Time of Death

0920

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTH CARE AVE.

4b. City, Town, or Location of Death

BALTO

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-20-1740

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 29 1924

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4401 N. ROGERS AVE APT B1

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

Omni HOTEL

17. Father's Name (First, Middle, Last)

Robert Bland

18. Mother's Name (First, Middle, Maiden Surname)

Cora Bell Hooper

19a. Informant's Name/Relationship (Type, Print)

Paula Edison - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4401 N. ROGERS AVE APT B1 BALTO MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST UET

Date

12-8-99

20c. Location - City or Town, State

Owings Mills Md.

21. Signature of Funeral Service Licensee

Flynn B. Harris

22. Name and Address of Facility

maech Funeral Home West Inc
4300 Wabash Ave. Balto Md 21215

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE/POSSIBLE ACUTE MYOCARDIAL INFARCTION

30 MIN.

Due to (or as a consequence of):

b. PULMONARY EDEMA

1 WEEK

Due to (or as a consequence of):

c. RENAL FAILURE

~2 YEARS

Due to (or as a consequence of):

d. CORONARY ARTERY DISEASE

~2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Russell E. Sparks MD

29c. License number

D50533

29d. Date signed (Month, Day, Year)

12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell H. Sparks MD 3449 WILKINS AVE, SUITE 300, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Russell E. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-0000.

Physician
/Medical
ExaminerNAME
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2

15

DEC 3 1983

34WE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38317

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

PATRICIA ANN MOUN

2. Date of Death

Month 11 Day 26 Year 99

3. Time of Death

4:45 AM

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

468 24 4276

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

MARCH 16, 1929

9. Birthplace (State or Foreign Country)

Eau Claire, WI

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

SEAFORD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

126 Holly Oak Drive

10f. Zip Code

19973

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Library Secretary

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Elroy Edward Ledebur

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Benson

19a. Informant's Name/Relationship (Type, Print)

Dr. Stanley G. Moun, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

126 Holly Oak Dr, Seaford, DE 19973

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory

Date

11/27/99

20c. Location - City or Town, State

DOVER, DE.

21. Signature of Funeral Service Licensee

Lewis D. McNatt

22. Name and Address of Facility

McNatt Funeral Home
50 Commerce St, Harrington, DE 19952

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Gastrointestinal Hemorrhage

Approximate Interval Between Onset and Death

3 hours

Due to (or as a consequence of):

Stress gastritis

24 hours

Due to (or as a consequence of):

Sepsis

24 hours

Due to (or as a consequence of):

Multisystem organ failure

24 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Coronary Artery Disease

Aortic Valve Stenosis

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Justice Julia MD

29c. License number

D 41813

29d. Date signed (Month, Day, Year)

11-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Justice Julia MD 201 Pine Bluff Road Salisbury MD 21801

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Benita G. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

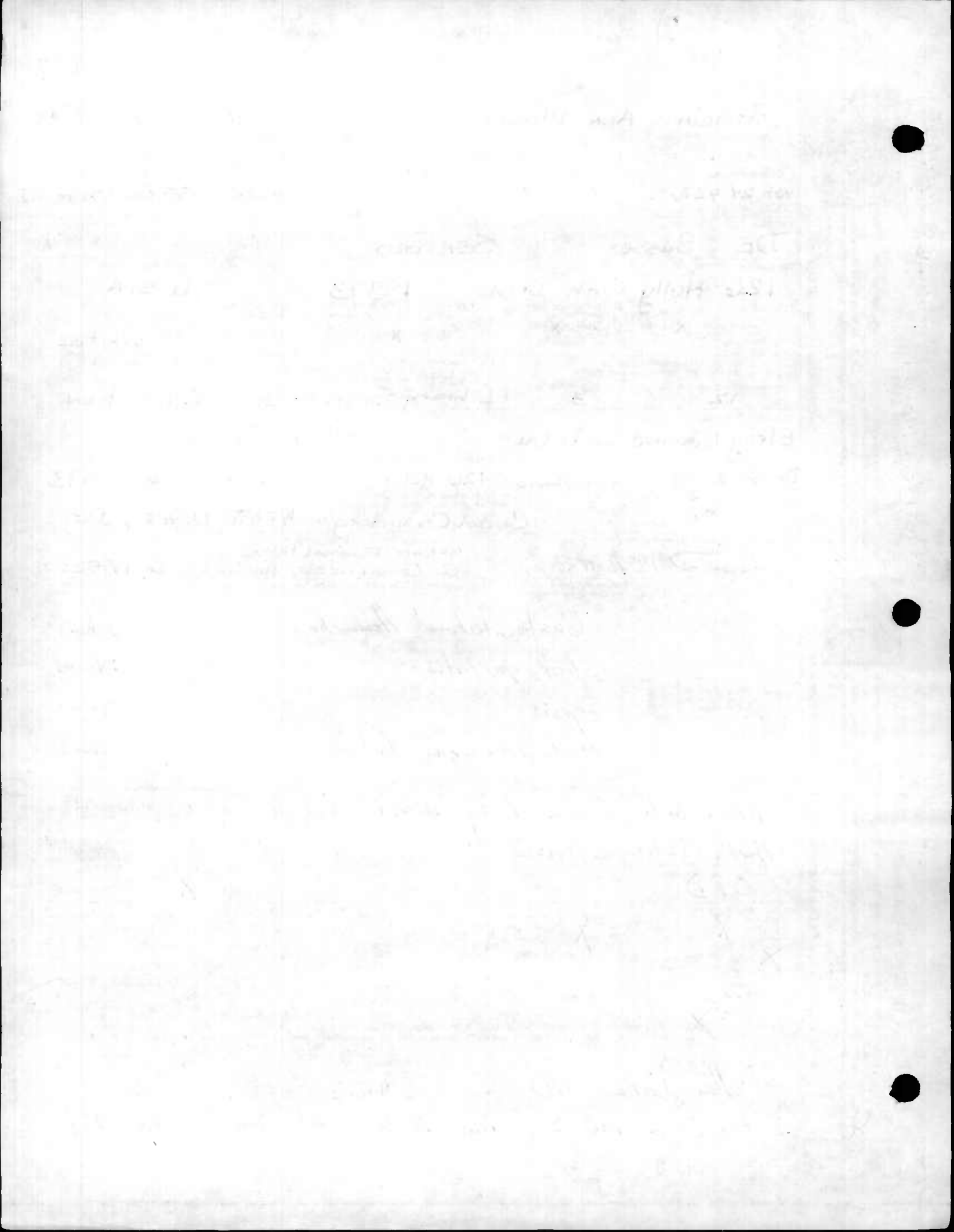
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#18 perFHG784 6/2/2000 EW

State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFH G778 121/0/99 EW(217-58-5201) Certificate of Death

Reg. No.

99 38318

| | | | | | | | | | | | | | | | |
|---|---|--|---|---|---|---|--|---|---|---|--|--------------------------------------|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN NAKAS | | | | 2. Date of Death Month 12 Day 3 Year 99 | | | | 3. Time of Death 0615 | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) LORIE NURSING & REHAB. CENTER COLUMBIA MD. | | | | 4b. City, Town, or Location of Death COLUMBIA MD. | | | | 4c. County of Death HOWARD | | | | | | |
| Funeral Director | 5. Social Security Number 212-58-5201 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) 09.09.1921 | | 9. Birthplace (State or Foreign Country) Greece | | | | | | |
| | 10a. State MD | | | | 10b. County Harford | | 10c. City, Town or Location Aberdeen | | | | | | | | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 121 Rogers Street. | | | | 10f. Zip Code 21001 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker | | | | 16b. Kind of Business/Industry Own Home | | | | | | | |
| 17. Father's Name (First, Middle, Last) Demetrios Skenas | | | | 18. Mother's Name (First, Middle, Maiden Surname) Garifalia Kostrakis Eloni Kostrakis | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Arthur Nakas/ Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3826 Winchester Ln. Bowie, Md 20715 | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | | Date 12/6/99 | | 20c. Location - City or Town, State Baltimore, MD | | | | | | | |
| 21. Signature of Funeral Service Licensee Robert S. Asht | | | | 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home Inc. 2134 Willow Spring Rd. Baltimore, Md 21222 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular accident b. End-stage renal disease c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 2 months | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier [Signature] | | 29c. License number D21461 | | 29d. Date signed (Month, Day, Year) Dec 3, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Larry Moore 2 Knoll North, Columbia MD. 21045 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

continued next

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND#9 PER F.H. G778 12-7-99 J.A.

Reg. No.

99 38319

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA V. O'BANNON

2. Date of Death

Month Day Year
DECEMBER 5 1999

3. Time of Death

1930 Hrs

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

220-30-1010

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1914

9. Birthplace (State or Foreign Country)

MARYLAND
Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2800 Hollingsworth Rd.

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Black & Decker

17. Father's Name (First, Middle, Last)

Baylis Grimes

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Warrenner

19a. Informant's Name/Relationship (Type, Print)

Charles Keith O'Bannon -Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2800 Hollingsworth Rd., Reisterstown, Md. 21136

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Wilson U.M. Ch. Cem.

Data

Dec. 9, 1999

20c. Location - City or Town, State

Long Green, Md.

21. Signature of Funeral Service Licensee

H. J. Schhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd., Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. MRSA PNEUMONIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

MYOCARDIAL INFARCTION, CAD.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ravi MD

29c. License number

D37333

29d. Date signed (Month, Day, Year)

DECEMBER 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. RAVI MD, NHC, BALTIMORE, MD 21133

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

B. J. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-695-2020.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

0001-5397/97/0005-0000\$05.00/0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38320

| | | | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY PEAKER | | | | 2. Date of Death Month 11 Day 21 Year 99 | | | | 3. Time of Death 6 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) BOX SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 212-14-9691 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 29, 1907 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 9619 Winands Rd. | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | | 16b. Kind of Business/Industry Private | | | |
| | 17. Father's Name (First, Middle, Last) Joshua Ballard | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Fisher | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ruth Ross - daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9619 Winands Rd. Randallstown, MD. 21133 | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cem. | | 20c. Location - City or Town/State 11/26 Woodlawn, Maryland | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Kevin Parker | | | | 22. Name and Address of Facility Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD 21229 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. RENAL FAILURE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Rosita R. Cruz | | 29c. License number D0030355 | | 29d. Date signed (Month, Day, Year) 11-21-99 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosita R. Cruz M.D. BOX SECOURS HOSPITAL | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature [Signature] | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38321

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Hattie Powell</i> | | | | 2. Date of Death Month <i>December</i> Day <i>01</i> Year <i>1999</i> | | 3. Time of Death <i>0450 am</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>St. Agnes Healthcare</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>N/A</i> | |
| Funeral Director | 5. Social Security Number <i>179-14-7420A</i> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>92</i> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | 8. Date of Birth (Month, Day, Year) <i>Jan. 29, 1907</i> | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>Pennsylvania</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>Philadelphia</i> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <i>2137 Marston St.</i> | | | | 10f. Zip Code <i>19121</i> | | 10g. Citizen of What Country? <i>USA</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Caterer</i> | | 16b. Kind of Business/Industry <i>Betty the Caterer</i> | | |
| 17. Father's Name (First, Middle, Last) <i>William P. Powell</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Amanda Scott</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>grand Priscilla Winchester-daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>604 N. Chapel Gate Lane Balto, MD. 21229</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Mem. Park</i> | | Date <i>12/7</i> | | 20c. Location - City or Town/State <i>Arbutus Maryland</i> | | |
| 21. Signature of Funeral Service Licensee <i>Kevin Parker</i> | | | | 22. Name and Address of Facility <i>Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, Maryland 21229</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pancreatic Cancer</i> Due to (or as a consequence of): b. <i>metastatic disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death <i>months</i> <i>months</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>R. Parikh M.D.</i> | | | | 29c. License number <i>P11698</i> | | 29d. Date signed (Month, Day, Year) <i>December 01, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>R. PARIKH 900 Caton AVE Baltimore, MD 21229</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 7 1999</i> | | | | 32. Registrar's Signature <i>Benjamin Sparks</i> | | | | |

ORIGINAL



WVNE

1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38322

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Robert Paesch

2. Date of Death

Dec 4 1999

3. Time of Death

2:45AM

4a. Facility Name (If not institution, give street and number)

7514 Eagle Walk Ct. Apt. D

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-18-5900

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 17 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7514 Eagle Walk Ct. #D

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

-

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

foreman

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

John R. Paesch

18. Mother's Name (First, Middle, Maiden Surname)

Clara unknown

19a. Informant's Name/Relationship (Type, Print)

Roger D. Paesch - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7514 Eagle Walk Ct. #D Baltimore Md 21237

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel-Bel Air

Date

Dec 7 1999

20c. Location - City or Town, State

Forest Hill Md

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic myocardial infarction

Due to (or as a consequence of): Hypertensive atherosclerotic Cardiovascular disease

Approximate Interval Between Onset and Death

hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Bernard R. Ziegler MD

29c. License number

D06973

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Gerald Maggid 8100 Harford Rd. Baltimore, Md. 21234

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Bernard R. Ziegler

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten signature

1981 1 30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38323

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Charles Portera

2. Date of Death

Month Day Year
Dec. 4, 1999

3. Time of Death

4:45 pm

4a. Facility Name, (If not institution, give street and number)

720 S. Ponca Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-01-4299

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/12/1910

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

720 S. Ponca Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Checker

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

Salvatore Portera

18. Mother's Name (First, Middle, Maiden Surname)

Francesca Testa

19a. Informant's Name/Relationship (Type, Print)

Catherine Portera/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

720 S. Ponca Street, Balto, Md. 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Demetrios Cem

Date

12/7

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Dana S. Simpler

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Road, Balto, Md 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOREXIA

Due to (or as a consequence of):

6mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Dysphagia

Due to (or as a consequence of):

6mo

c. Stroke

Due to (or as a consequence of):

3 years

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dana S. Simpler MD

29c. License number

D35170

29d. Date signed (Month, Day, Year)

12-6-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANA S. SIMPLER MD 808-810 S. CONKLING ST BALTO MD 21224

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Dana S. Simpler

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland permit. Pages 3 and 4 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

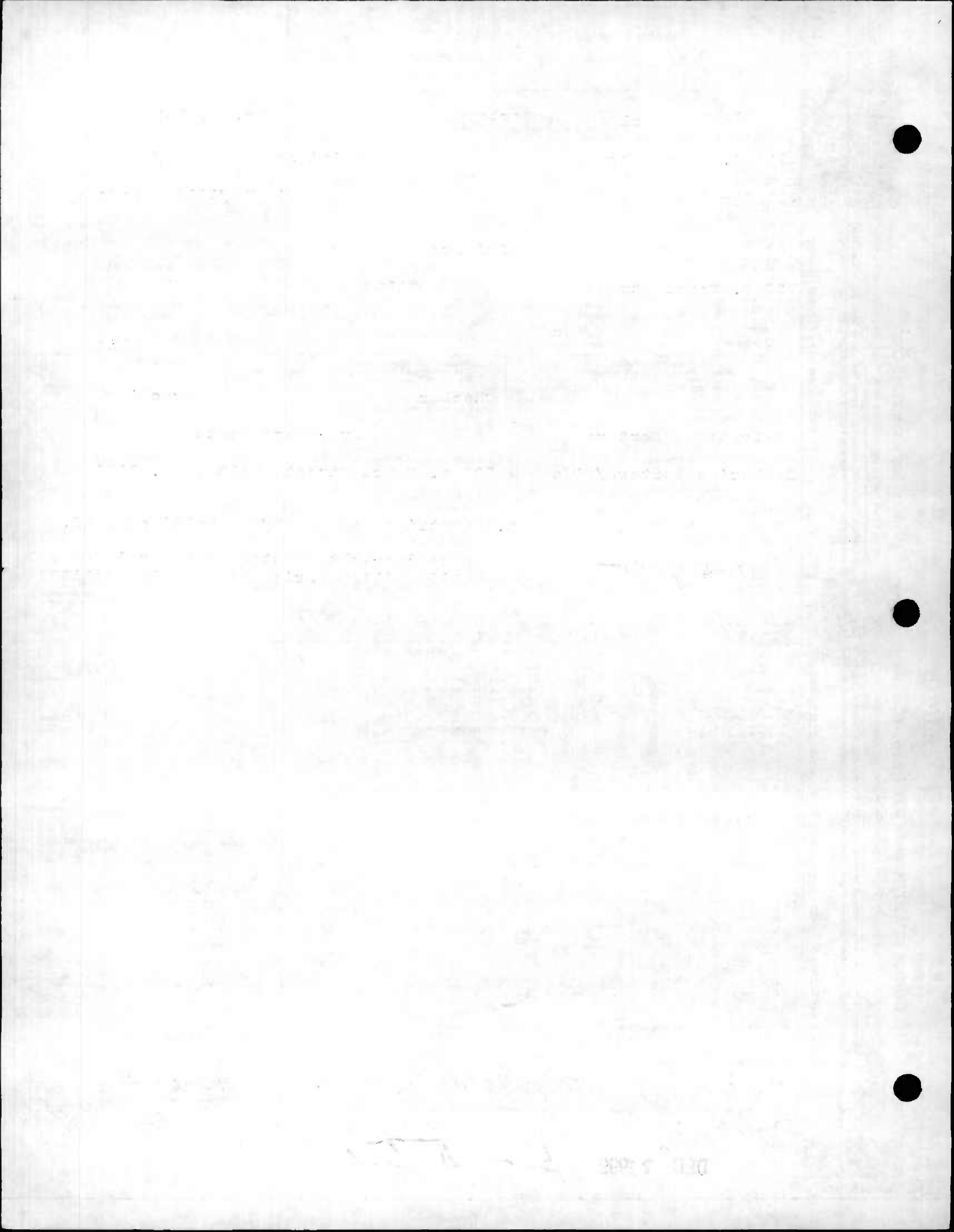
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38324

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARA ELIZABETH PATRO | | | | | | 2. Date of Death Month Day Year DEC. 1 1999 | | 3. Time of Death 1:35PM | |
| | 4a. Facility Name (If not institution, give street and number) Armcast Nursing Home | | | | | | 4b. City, Town, or Location of Death Baltimore County | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 215-10-9869 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 14, 1908 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore City | | 10c. City, Town or Location Baltimore City | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 1600 W. Mt. Royal Avenue | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tailoring | | | 16b. Kind of Business/Industry Textile Workers | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Joseph Guidice | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Catherine Tudor | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth L. Lassahn | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 Winford Rd. Baltimore, Md. 21239 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | Date 12-6-1999 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Myocardial Infarction</u> Due to (or as a consequence of): b. <u>Cerebrovascular accident</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 1 wk 2 yr | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier | | | | 29c. License number 031865 | | 29d. Date signed (Month, Day, Year) 12-2-99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael O. Kizore, MD 821 N Guntow Street Baltimore MD 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38325

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANTHONY PANCESZYN, SR.

2. Date of Death
Month Day Year
December 5, 19993. Time of Death
9:55 p.m.Funeral
Director

4a. Facility Name (If not institution, give street and number)

GENESIS MULTI-MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

213-07-9891

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 25, 1908

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

600 S. DECKER AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SELF-EMPLOYED

16b. Kind of Business/Industry

TAVERN OWNER

17. Father's Name (First, Middle, Last)

ANDREW PANCESZYN

18. Mother's Name (First, Middle, Maiden Surname)

VICTORIA UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

VICTORIA ELIESON/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6304 N. CHARLES STREET, BALTIMORE, MARYLAND 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. STANISLAUS CEMETERY 12/9/99

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME

1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Cerebral vascular accident

Approximate Interval Between Onset and Death

Unknown

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27569

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Kettelman 1838 Green Tree Rd #300

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

B Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-524-2024.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

DEC 1 1968

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PER MEO G 119 1-5-2000 WR. Certificate of Death

99 38326

Reg. No.

AMEND ITEMS: #23 PART I, 27, 28A-F

| | | | | | | | | | | | | |
|---|---|--|---|------------------------------------|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VELLVA C. POPE | | | | 2. Date of Death Month Day Year December 04, 1999 | | | | 3. Time of Death 9:16 A.M. | | | |
| | 4e. Facility Name (If not Institution, give street and number) Bon Secours Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 219-78-1025 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 39 Yrs. | | 8. Date of Birth (Month, Day, Year) 07-19-60 | | 9. Birthplace (State or Foreign Country) MD | | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10e. Street and Number 2014 N. BENTLOU ST. | | | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | | | 16b. Kind of Business/Industry HEALTH | | | |
| | 17. Father's Name (First, Middle, Last) NORWOOD POPE | | | | 18. Mother's Name (First, Middle, Maiden Surname) LILLIE FULTON | | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print) NORWOOD POPE FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3219 BRIGHTWOOD AVE., BALTO. MD 21207 | | | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | 20c. Location - City or Town, State 12-8-99 RANDALLSTOWN, MD | | | | | | | |
| | 21. Signature of Funeral Service Licensee Vaughn C. H. | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION AND PULMONARY THROMBOEMBOLISM | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 12-4-99 | | 28b. Time of Injury Found: 5:00 | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | | |
| 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Theodore McKing | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 05, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore McKing 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 06 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

00000 44

DEC 8 1986

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38327

| | | | | | | | | | |
|---|---|---|--|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Nolan Richardson</i> | | | | 2. Date of Death Month <i>12</i> Day <i>4</i> Year <i>99</i> | | 3. Time of Death <i>10:17A</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>VA Medical Center, Baltimore</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore, MD</i> | | 4c. County of Death <i>N/A</i> | | |
| Funeral Director | 5. Social Security Number <i>219-30-0388</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>63</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>3-28-36</i> | 9. Birthplace (State or Foreign Country) <i>MD.</i> | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State <i>MD</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>BALTIMORE City</i> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <i>1817 N. Caroline St.</i> | | | | 10f. Zip Code <i>21213</i> | | 10g. Citizen of What Country? <i>USA</i> | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>54-57</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) <i>N/A</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>U.S. Postal Clerk</i> | | 16b. Kind of Business/Industry <i>Post Office</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>Daniel Richardson</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Margaret Carter</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Annette Packer (sister)</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1817 N. Caroline St. Baltimore, Md. 21213</i> | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest (VA)</i> | | Date <i>12/9/99</i> | | 20c. Location - City or Town, State <i>BALT. MD.</i> | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | | 22. Name and Address of Facility <i>BETTS Funeral Home 1139 N Caroline St BALT. MD 21213</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>renal failure</i> <i>respiratory failure</i> | | | | | | | | Approximate Interval Between Onset and Death <i>1 week</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>renal failure</i> <i>respiratory failure</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature] MD</i> | | 29c. License number <i>085P2</i> | | 29d. Date signed (Month, Day, Year) <i>12-4-99</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Pat Ricalde 22 S. Greene St. Baltimore, MD 21230</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 7 1999</i> | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

15500

DEC 2 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38328

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Adrian Eugene Rausch, Sr.

2. Date of Death

Dec. 1 1999

3. Time of Death

11:48pm

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GIEN BURNIE A COUNTY

4c. County of Death

GIEN BURNIE A COUNTY

Funeral
Director

5. Social Security Number

270-40-3706

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 16, 1946

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

217 Ritchie Hwy.

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking Company

17. Father's Name (First, Middle, Last)

Lewis Rausch

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Sharretts

19a. Informant's Name/Relationship (Type, Print)

Robin L. Rausch (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4849 Hazelwood Ave. Balto., MD. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

12/4/99

20c. Location - City or Town, State

Balto., MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

3204 Mountain Road Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction.

Due to (or as a consequence of):

5 mch.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. occlusive coronary artery disease

Due to (or as a consequence of):

15 yrs.

c. Hypertension

Due to (or as a consequence of):

15 yrs

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

left ventricular dysfunction.

glucose intolerance

cigarette smoking

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nancy V. Strahan M.D.

29c. License number

D0024927

29d. Date signed (Month, Day, Year)

12/3/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANCY V. STRAHAN M.D. - 10755 FALLS RD; LUTHERVILLE

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

[Signature]

MD 21093

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-6000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #23 PER MD G778 12-6-99 WR.
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM: #18 PER F.H. G778 12-6-99

Reg. No. 99 38329

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY ROBINSON | | | | 2. Date of Death Month Day Year NOVEMBER 16, 1999 | | 3. Time of Death 2:14 PM | |
| | 4a. Facility Name (If not institution, give street and number) ROLAND PARK PLACE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-12-1409 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 25, 1907 | |
| | 9. Birthplace (State or Foreign Country) RUSSIA | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 3313 OLD FOREST ROAD | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATIVE ASSISTANT | | 16b. Kind of Business/Industry VENETIAN BLINDS | | | |
| | 17. Father's Name (First, Middle, Last) ARRUM ACKERMAN | | 18. Mother's Name (First, Middle, Maiden Surname) SARAH ARONOWITZ ARONOVITZ | | 19a. Informant's Name/Relationship (Type, Print) ZELIG ROBINSON / SON | | | |
| Physician /Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 CHARLCOTE PLACE - BALTIMORE, MD 21218 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL CEMETERY | | 20c. Location - City or Town, State 11/18/99 BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PROBABLE a. Probable Intestinal Obstruction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death 36 hrs | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Arteriosclerosis Demencia Ischemic Cardiac Infarction | | | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | 29b. Signature and title of certifier  | |
| | 29c. License number D 12399 | | 29d. Date signed (Month, Day, Year) November 17, 1999 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES D. JOHNSON JR MD 6565 S. CHARLES ST #509 BALTIMORE, MD 21204 | | | | | | 31. Date filed (Month, Day, Year) DEC 06 1999 | |
| | 32. Registrar's Signature  | | | | | | | |

85891

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38330

amended item #7 per fh g778 12/8/99 ah

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|---------------------------------------|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry M. Ray | | | | 2. Date of Death Month Day Year Dec. 02 1999 | | 3. Time of Death 5:05AM | | |
| | 4a. Facility Name (If not institution, give street and number) Ridgeway Manor Nursing Home | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 212-03-8111 | 6. Sex H <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 02, 1913 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Arbutus | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 1218 Locust Avenue | | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tool & Dye Maker | | | 16b. Kind of Business/Industry Manufacturer | | | |
| | 17. Father's Name (First, Middle, Last) Natzina Ray | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Dorsch | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Diana L. Goldberg (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 Locust Avenue Arbutus, MD 21227 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Western Cemetery | | Data 12/4/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| | 21. Signature of Funeral Service Licensee <i>Sharon McLaughlin</i> | | | | 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>Geetha Raju MD</i> | | | | 29c. License number DQ 7541 | | 29d. Date signed (Month, Day, Year) December 2, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEETHA RAJU, 4367 Hollins Ferry Rd, Baltimore MD 21227 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

00000

Handwritten signature

DEC 1 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38331

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRYCE W RILEY

2. Date of Death

November 20 1999

3. Time of Death

3:50 P.M.

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

217-11-8198

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

20

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 23, 1979

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

28 Insley Way

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

William George Riley

18. Mother's Name (First, Middle, Maiden Surname)

Regina Thorry

19a. Informant's Name/Relationship (Type, Print)

Mr. William G. Riley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 Insley Way Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Moreland Memorial Cem. 11-23-99

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Donald C. Chasch

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Maryland

21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. EPIDURAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
November 20, 1999

28b. Time of Injury

12:20 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

WHEELCHAIR FLIPPED OVER ON PATIENT'S HEAD

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

gymnasium

28f. Location (Street and Number or Rural Route Number,
City or Town, State)3335 Grappling Avenue
Baltimore, Md29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jenny Za Williams - M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

November, 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenny Za Williams

2401 West BELVEDERE AVENUE BALTIMORE, MARYLAND

21215

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Dennis B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1885

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38332

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANCIS W. REDDING | | | | | 2. Date of Death Month Day Year DECEMBER 5, 1999 | | | 3. Time of Death 8:45 P.M. | | |
| | 4a. Facility Name (If not Institution, give street and number) 8543 WILLOW OAK ROAD | | | | | 4b. City, Town, or Location of Death RIDGELEIGH | | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 216-28-2847 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 2/11/33 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location RIDGELEIGH | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 8543 WILLOW OAK ROAD | | | | | 10f. Zip Code 21234 | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) _____ | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAINTER | | | 16b. Kind of Business/Industry SIGN COMPANY | | | | |
| 17. Father's Name (First, Middle, Last) ROBERT REDDING | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY ELIZABETH WINCHESTER | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ALLAYNE C. REDDING WIFE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8543 WILLOW OAK ROAD BALTIMORE, MD 21234 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GAR. | | | Date 12/8/99 | | 20c. Location - City or Town, State COCKEYSVILLE, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Heather N. Hay</i> | | | | | 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>bronchogenic carcinoma</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 10 min. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypercholesterolemia</i> <i>cerebral infarction</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | 29c. License number D-14957 | | 29d. Date signed (Month, Day, Year) 12-6-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Stephen R. Smith, MD, 8709 Harford Rd., Baltimore, Md. 21234</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AMEND ITEMS: #23 PART I, II, 27 PER Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--------------------|---|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Calvin Eugene Schlick | | | | | | 2. Date of Death Month Day Year NOV. 29, 1999 | | 3. Time of Death 2222 PM | | |
| | 4e. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL E.R. | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 216-76-8253 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 25, 1955 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 2363 Washington Blvd. | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | | 16b. Kind of Business/Industry Manufacturing | | | | |
| 17. Father's Name (First, Middle, Last) Malcolm Schlick | | | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Mary Triplett | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Schlick - mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 S. Bentalou St., Baltimore, Md. 21223 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Mem. Gardens | | 20c. Location - City or Town, State 12/07/99 Marriottsville, Md. | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. ALCOHOLISM | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) NOV. 30, 1999 | | | |
| 30. Name and address of person who completed causa of death (Item 25a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WRC
99-7184-025
JEFFREY W.
SMID AMEND ITEMS: #23 PART I, 27 PER ME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

778 12-17-99 WR.

Reg. No.

99 38334

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0020.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) JEFFREY William SMID | | | | 2. Date of Death Month NOVEMBER Day 30 , Year 1999 | | | | 3. Time of Death 12:35 PM. | | | |
| 4a. Facility Name (If not institution, give street and number) FALLSTON GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death FALLSTON | | | | 4c. County of Death HARFORD | | | |
| 5. Social Security Number 217 48 4583 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN. 30, 1955 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County HARFORD | | 10c. City, Town or Location Bell Air | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 1302 RUTHRIDGE COURT | | | | 10f. Zip Code 21014 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 4 YRS. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICAL THERAPIST | | | | 16b. Kind of Business/Industry PROTHERO AND SMID BATHING AND COMMUNITY REHABILITATION CENTER | | | |
| 17. Father's Name (First, Middle, Last) Edwin SMID | | | | 18. Mother's Name (First, Middle, Maiden Surname) DOROTHEA CLOSE | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) SUSAN G. SMID | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 RUTHRIDGE COURT BELL AIR, MARYLAND 21014 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL - BELL AIR, P.A. | | Date DEC. 6, 1999 | | 20c. Location - City or Town, State FOREST HILL MARYLAND | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELL AIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL MARYLAND | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DEC. 01, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 7 1999 | | 32. Registrar's Signature | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38335

Amended Item#10c,10e perFH G778 12/07/99 FW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHRYN STRASBAUGH

2. Date of Death

11

28

99

3. Time of Death

12:10pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7841 N. Cove Rd

4b. City, Town, or Location of Death

Sparrows Pt

4c. County of Death

Baltimore

5. Social Security Number

215 74 5596

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

0907 1908

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

~~Edgemere~~

Sparrows Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7841 N. Cove RD

10f. Zip Code

21219

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ross Herr

18. Mother's Name (First, Middle, Maiden Surname)

Grace (Stoner)

19a. Informant's Name/Relationship (Type, Print)

John Strasbaugh/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7708 N. Point Creek RD. Edgemere, MD 21219

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore/Washgt.Cre. 11/29/99 Laurel, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M. K. Marshall

22. Name and Address of Facility

BRADLEY-ASHION-MATTHEWS FUNERAL HOMES, INC.
2134 WILLOW SPRINGS BALTIMORE, MARYLAND 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Congestive Heart Failure

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury of Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Crystal Simpson M.D.

29c. License number

054502

29d. Date signed (Month, Day, Year)

11-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crystal Simpson M.D. 5505 Hopkyns Bayview Circle Baltimore, MD 21224

31. Date filed (Month, Day Year)

DEC 7 1999

32. Registrar's Signature

James S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

STOCK 11/11/11

2/1/11

DEC 1 1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38336

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Bertha Spiess | | | | | 2. Date of Death Month Day Year December 3 1999 | | | 3. Time of Death 4:00 am | |
| | 4a. Facility Name (If not institution, give street and number) Fairfield Nursing Home | | | | | 4b. City, Town, or Location of Death Crownsville | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 218-62-1232 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 9, 1904 | | 9. Birthplace (State or Foreign Country) Germany | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 5215 Font Avenue | | | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Martin Baum | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Luise Marie Sauther | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Kurt P. Spiess (Son) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 770 Barger Drive, Crownsville, MD 21032 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | | Date 12/04 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee Therese P. Kutta | | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 weeks | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier D. J. Smith | | | | | 29c. License number D 38958 | | 29d. Date signed (Month, Day, Year) 12/3/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daleit Singh Sekhu 1413 Hannaford Road #106 Odenton MD 21113 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | | 32. Registrar's Signature G. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38337

| | | | | | | | | |
|--|--|--|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jesse Stern | | | | 2. Date of Death Month Dec. Day 01 , Year 99 | | 3. Time of Death 12:15pm | |
| | 4a. Facility Name (If not institution, give street and number) 13-B Timber Creek Court | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Essex | |
| Funeral Director | 5. Social Security Number 216-42-6895 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) 09-28-42 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Essex | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 13 Timber Creek Court | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High Sch. Grad College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Recreations & Parks City of Baltimore | | | |
| | 17. Father's Name (First, Middle, Last) Willie Stern | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ethel Powell | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ethel Sawyer | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 4320 Clareway Avenue Baltimore, Maryland | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem.Pk. Cem. | | 20c. Date 12-06-99 | | 20d. Location - City or Town, State Randallstown, MD | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic pancreatic cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death 6 months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 044944 | | 29d. Date signed (Month, Day, Year) December 3rd, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Walker 3333 North Calvert Street Baltimore Md 21202 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

DEC 9 7 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38338

| | | | | | | | | | | |
|---|---|---|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARIE H. SCOTT | | | | | | 2. Date of Death Month Day Year December 2, 1999 | | 3. Time of Death 3:45 pm | |
| | 4a. Facility Name (If not institution, give street and number) Fallston General Hospital | | | | | | 4b. City, Town, or Location of Death Fallston | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 217-05-5560 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) March 12, 1916 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Fallston | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3113 Preakness Drive | | | | | | 10f. Zip Code 21047 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4or 5+) : | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Frank A. Schraml | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maude Frisby | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Kenneth R. Scott (Son) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Preakness Drive, Fallston, MD 21047 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | | Date 12/6/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Schmunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Perforated Viscus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D47631 | | 29d. Date signed (Month, Day, Year) December 2, 1999 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Antoinette Spetz MD Fallston General Hospital Fallston, MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature | | | | | | | | |

DEC 0 1 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38339

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT STANLEY SHARP

2. Date of Death

Month Day Year
December 03, 1999 2:03 p.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-01-9996

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3/29/11

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1000 EAST JOPPA ROAD APT. 513

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
WHITE15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

INSPECTOR

16b. Kind of Business/Industry

FACTORY

17. Father's Name (First, Middle, Last)

ROBERT S. SHARP

18. Mother's Name (First, Middle, Maiden Surname)

MARGRETTA MULLIKIN

19a. Informant's Name/Relationship (Type, Print)

LYNNE DVORAK DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1333 HALSTEAD ROAD BALTIMORE, MD 21234

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

12/6/99 CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE CARDIOGENIC SHOCK

48 hours

Due to (or as a consequence of):

b. ACUTE ANTERIOR MYOCARDIAL INFARCTION 5 days

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

NA

28b. Time of
injury

NA

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

NA

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

NA

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D25010

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SERENA R. NOLAN, MD 8035A HARFORD RD BALTIMORE MD 21234

State
Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Serena R. Sparks

ORIGINAL

Sharp, Robert
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38340

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALMA

TAIT

2. Date of Death

December 04, 1999

3. Time of Death

11:51 AM

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

414 09 5316

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

5-2-12

9. Birthplace (State or Foreign Country)

TENN.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

945 S. Marlin Ave.

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

JOSEPH Aaron

18. Mother's Name (First, Middle, Maiden Surname)

Dora Brown

19a. Informant's Name/Relationship (Type, Print)

JOYCE Winkler

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

705 MT. Holly St. BALT. MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

5/1/99

20c. Location - City or Town, State

BALT. MD.

21. Signature of Funeral Service Licensee

Betts Funeral Home

22. Name and Address of Facility

BETTS Funeral Home

1129 N. Caroline St.

BALT. MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXEMIA

Due to (or as a consequence of):

40 minutes

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. VENTRICULAR ARRHYTHMIA

Due to (or as a consequence of):

40 minutes

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

5 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

RENAL TUBULAR ACIDOSIS

CLOSTRIDIUM DIFFICILE COLITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D53462

29d. Date signed (Month, Day, Year)

DECEMBER 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUDY MURKES 9000 FRANKLIN SQUARE DR. BALTO., MD. 21237

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Benjamin G. Sparks

State Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

TAIT, ALMA

AH

John W. ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38341

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOANNE Latunda THOMPSON

2. Date of Death
Month Day Year

December 4 1999 4:30 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6 Tomber Ct.

4b. City, Town, or Location of Death

BALTIMORE, MD

4c. County of Death

N/A

5. Social Security Number

217-76-9236

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12-14-59

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State
MD10b. County
N/A

10c. City, Town or Location

BALTIMORE, MD. 21207

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 Tomber Ct.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

correction officer

16b. Kind of Business/Industry

Jessup Prison

17. Father's Name (First, Middle, Last)

Ernest Diggs

18. Mother's Name (First, Middle, Maiden Surname)

Gloria Mae Redd

19a. Informant's Name/Relationship (Type, Print)

Jessie Thompson (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Tomber Ct. BALT. MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial

Date

12/10/99

20c. Location - City or Town, State

Woodlawn, MD.

21. Signature of Funeral Service Licensee

Patricia L. Lott

22. Name and Address of Facility

BALT. MD 21213
BETHS FUNERAL HOME 1129 N. CARLINE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE SCLEROSIS

Due to (or as a consequence of):

b. SYSTEMIC LUPUS ERYTHEMATOSUS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rita A. Lott, MD

29c. License number

D0053915

29d. Date signed (Month, Day, Year)

December 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA A. LOTT, MD 5601 LOCH RAVEN BLVD BALT MD 21239

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

ORIGINAL

1000 7-10-11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38342

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mariam D. Treslar

2. Date of Death

Month
12/Day
01Year
1999

3. Time of Death

3:00PM

4a. Facility Name (If not institution, give street and number)

Maryland Masonic Homes

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-46-3048

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10 05 1897

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore,

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

300 International Circle Room T26

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: USA

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Pennsylvania Schools

17. Father's Name (First, Middle, Last)

George Adam Fice

18. Mother's Name (First, Middle, Maiden Surname)

Emma A. Chamberlain

19a. Informant's Name/Relationship (Type, Print)

Glen H. Treslar, Jr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16504 Garfield Avenue, Monkton, Maryland 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tioga Point Cemetery

Date

12/6/99

20c. Location - City or Town, State

Athens, Pennsylvania

21. Signature of Funeral Service Licensee

Lynn B. Henss

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Vascular Disease

Due to (or as a consequence of):

b. Advanced Age

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aneurism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Lewis, MD.

29c. License number

D41464

29d. Date signed (Month, Day, Year)

12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT LIBERTO, MD. 3708 PARK ST BALTO, MD 21224

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

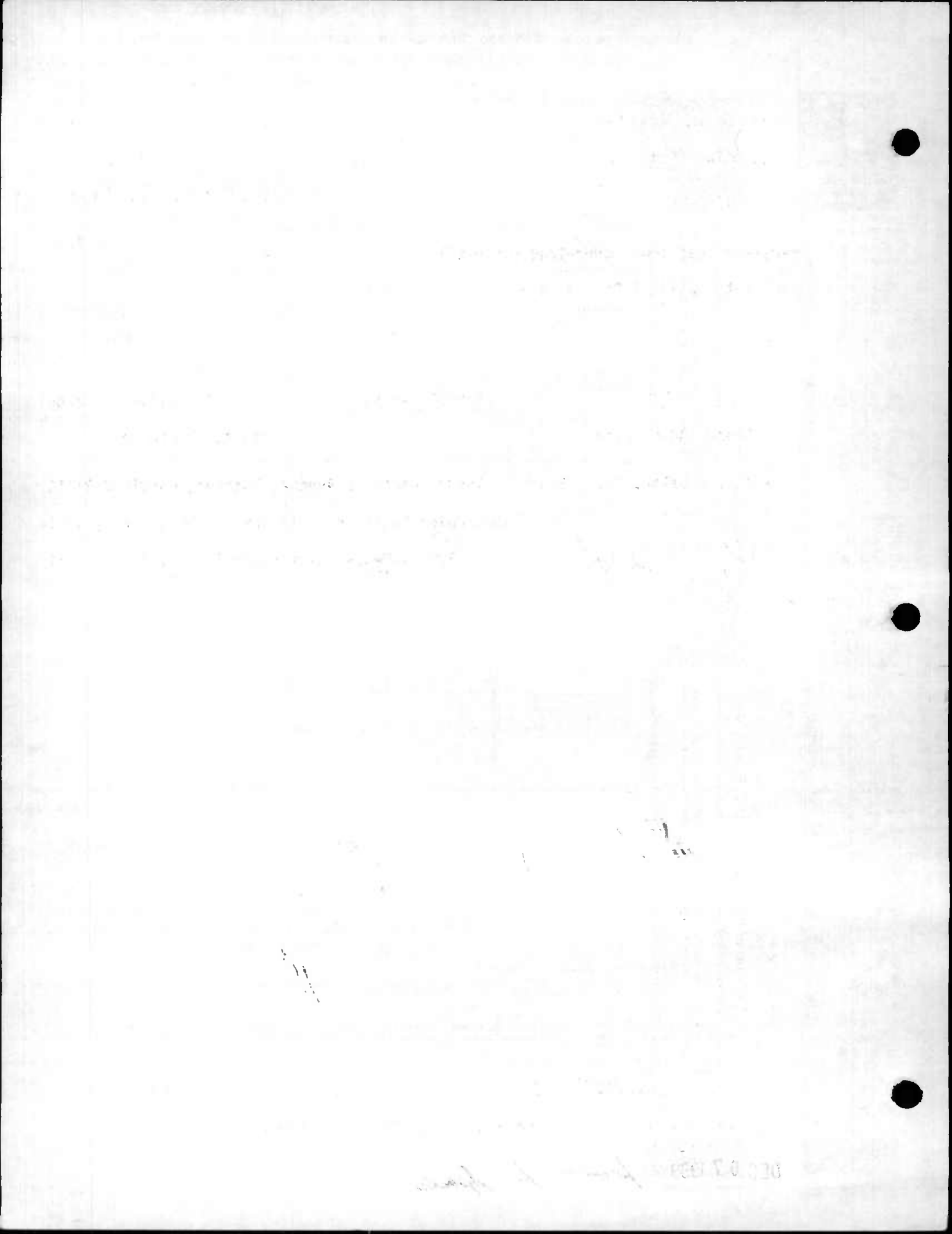
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38343

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bernard F. Thanner

2. Date of Death
Month Day Year
DECEMBER 4, 19993. Time of Death
3:57 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-24-7101

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 16, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10323 Greenside Dr.

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

police officer

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Bernard J. Thanner

18. Mother's Name (First, Middle, Maiden Summa)

Margaret L. Eckels

19a. Informant's Name/Relationship (Type, Print)

Amy J. Siedlecki

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1949 Youngstown Rd. Jarrattsville, Md 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem. Gdns.

Date

Dec. 8
1999

20c. Location - City or Town, State

Timonium, Md

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
2325 York Rd Timonium, Md 2108323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ANEURYSM, ABDOMINAL AORTIC RUPTURE

a. Due to (or as a consequence of):
HEMORRHAGE

b. Due to (or as a consequence of):

c. SEVERE CORONARY ARTERY DISEASE

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

S. S. S.

29c. License number

D 54274

29d. Date signed (Month, Day, Year)

12/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMER SAIEDY, M.D., 7401 OSLER DR., TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC

7 1999

32. Registrar's Signature

S. S. S.

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2026.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38344

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARION Edna Taylor

2. Date of Death

December 6, 1999 6:39 a.m.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5400 GIST AVENUE

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

121-01-0768A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 27, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5400 GIST AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Joshua Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Hawkins

19a. Informant's Name/Relationship (Type, Print)

Jacnita Taylor/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5400 GIST AVENUE Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National Cemetery

Date

12/6/99

20c. Location - City or Town, State

Baltimore City, Maryland

21. Signature of Funeral Service Licensee

Maggie Hawkins

22. Name and Address of Facility

Maggie Hawkins

5400 GIST AVENUE

Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CARDIOPULMONARY FAILURE

Due to (or as a consequence of):

b. POSSIBLE PULMONARY EMBOLI

Due to (or as a consequence of):

c. CARCINOMA OF GALLBLADDER,

Due to (or as a consequence of):

d. PANCREATODUODENAL

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER METASTASES

BILE DUCT OBSTRUCTION

S/P CA BREAST

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. C. Enrique

29c. License number

D14829

29d. Date signed (Month, Day, Year)

12/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.C. ENRIQUE 2435 W. BELVEDERE 21215

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

B. B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

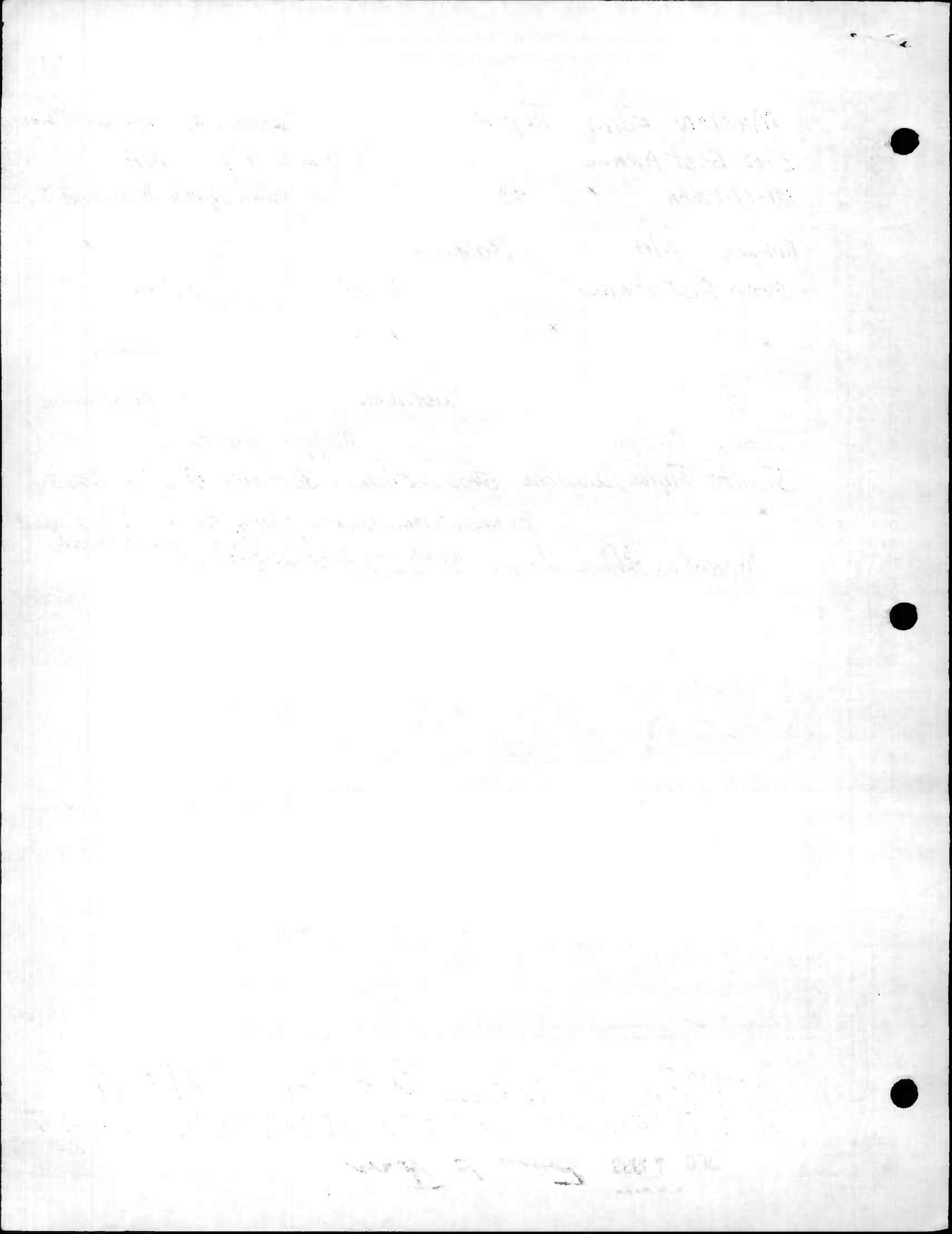
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 5053.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38345

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Josephine Caroline Thomas | | | | 2. Date of Death Month Day Year December 2, 1999 | | 3. Time of Death 7:00 p.m. | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 5819 Carrington Drive | | | | 4b. City, Town, or Location of Death White Marsh | | 4c. County of Death Baltimore Co. | | | | | | | |
| Funeral Director | 5. Social Security Number 217-18-2616 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 24, 1924 | 9. Birthplace (State or Foreign Country) Maryland | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore Co. | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number 7826 Eastdale Road | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? United States | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cost Accountant | | | 16b. Kind of Business/Industry Manufacturing | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Francis E. Heffernan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie E. Schaeck | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Josephine C. Kovacevich/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5819 Carrington Drive White Marsh, MD 21162 | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. | | Date 12/6/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | | | |
| | 21. Signature of Funeral Service Licensee Michael E. Canapp | | 22. Name and Address of Facility LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214 | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Deep Venous Thrombosis Due to (or as a consequence of): c. Pulmonary Embolism Due to (or as a consequence of): d. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 3 Months | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Venous Thrombosis Pulmonary Embolism Chronic Obstructive Pulmonary Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Daughter's Residence | | | | | | | | | | | |
| State Registrar | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| | 29a. Certifier (Check only one) XX <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier Rodrigo B. Erlich, M.D. | | 29c. License number D0054911 | | 29d. Date signed (Month, Day, Year) December 06, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodrigo B. Erlich, M.D. 4940 Eastern Ave. A Bldg. Rm. 112 Baltimore, MD 21224 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature Rodrigo B. Erlich | | | | | | | | | | | | |

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

James

Tubman

2. Date of Death

Month

Day

Year

November 22, 1999

3. Time of Death

8:00 A.M.

4a. Facility Name (If not institution, give street and number)

Veterans Administration Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-54-0318

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

01-05-47

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

308 South Broadway

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Harry Tubman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Leona Nelson

19a. Informant's Name/Relationship (Type, Print)

Marlene Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

510 N. Linwood Avenue Baltimore, MD. 21205

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 11-30-99 Owings Mills, MD

Date

20c. Location - City or Town, State MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM. C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC CARCINOMA OF BOWEL COMPLICATED BY STAB WOUND OF ABDOMEN

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND 11-15-99

28b. Time of Injury

FOUND

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND: RESIDENCE

28d. Describe how injury occurred

SUBJECT STABBED SELF

28f. Location (Street and Number or Rural Route Number, City or Town, State)

308 SOUTH BROADWAY BALTIMORE, MARYLAND

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARRY A. KORTZ 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-2025.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38347

| | | | | | | | | | | | | | | |
|--|---|---|---|---|--|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Edward Weitzel | | | | | | 2. Date of Death Month Day Year DECEMBER 2, 1999 | | 3. Time of Death 1107 AM | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 3714 ROLAND AVENUE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | | | |
| Funeral Director | 5. Social Security Number 218-76-7623 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 43 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 8, 1956 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 3714 Roland Avenue | | | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Years of Special Education College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked | | | 16b. Kind of Business/Industry Never worked | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Joseph E. Weitzel | | | | 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Kroger | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Pamela Riley Sister-in-law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Dellwood Avenue, Baltimore, Maryland 21211 | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | | | 20c. Location - City or Town, State 12/6/99 Elkridge, Maryland | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Kym B. Henss</i> | | | | 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Bronchitis and Pulmonary Emphysema</i> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29c. License number O.C.ME. | | 29d. Date signed (Month, Day, Year) DECEMBER 3, 1999 | |
| | 29b. Signature and title of certifier <i>J. Pustan M.D.</i> | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestano 111 Penn Street, Baltimore, Maryland 21201</i> | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Mr. J. H. ...

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst.

Yours very truly,

J. H. ...

DEC 9 1 1893

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38348

| | | | | | | | | | | | | |
|---|--|---|---|---------------------------------------|--|---|---|-----------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ERMA DELOISE WEBSTER | | | | 2. Date of Death Month Day Year DECEMBER 4 1999 | | | | 3. Time of Death 7.20AM | | | |
| | 4a. Facility Name (If not Institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death BALTIMORE CITY | | | |
| Funeral Director | 5. Social Security Number 218-26-1546 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-06-24 | | 9. Birthplace (State or Foreign Country) MD | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 6651 Wycombe Way Apt. "D" | | | | 10f. Zip Code 21234 | | | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | | 16b. Kind of Business/Industry various trades | | | |
| | 17. Father's Name (First, Middle, Last) Carroll Bailey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lola Haskins | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Regina Webster | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 6651 Wycombe Way Apt "D" Baltimore, MD | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery | | Data 12-07-99 | | 20c. Location - City or Town, State Baltimore, MD | | | | | |
| | 21. Signature of Funeral Service Licensee Bernard D Johnson | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBRAL VASCULAR ACCIDENT Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death TWELVE DAYS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COLON CARCINOMA UROSEPSIS | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Dominique Mall, M.D. | | 29c. License number P 13455 | | 29d. Date signed (Month, Day, Year) DECEMBER 4 1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOMINIQUE MALL, GOOD SAMARITAN HOSPITAL | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature Bernard B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

REC'D 7 6 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38349

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donna D. McCray Wilkerson

2. Date of Death

Month Day Year
DECEMBER 1, 1999

3. Time of Death

9:31 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

219-56-4043

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08-16-54

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2636 Ashland Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th GradeCollege (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Baltimore Gas & Electric Company

17. Father's Name (First, Middle, Last)

Lawrence McCray

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Hatcher

19a. Informant's Name/Relationship (Type, Print)

Carolyn Turner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2369 Seamon Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Pk. Cem. 12-08-99 Arbutus, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E.North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease
Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal transplant, obstructive

pulmonary disease, Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

1365848998

29d. Date signed (Month, Day, Year)

December 01, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Greenwald 900 Caton Avenue Baltimore, MD 21229

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

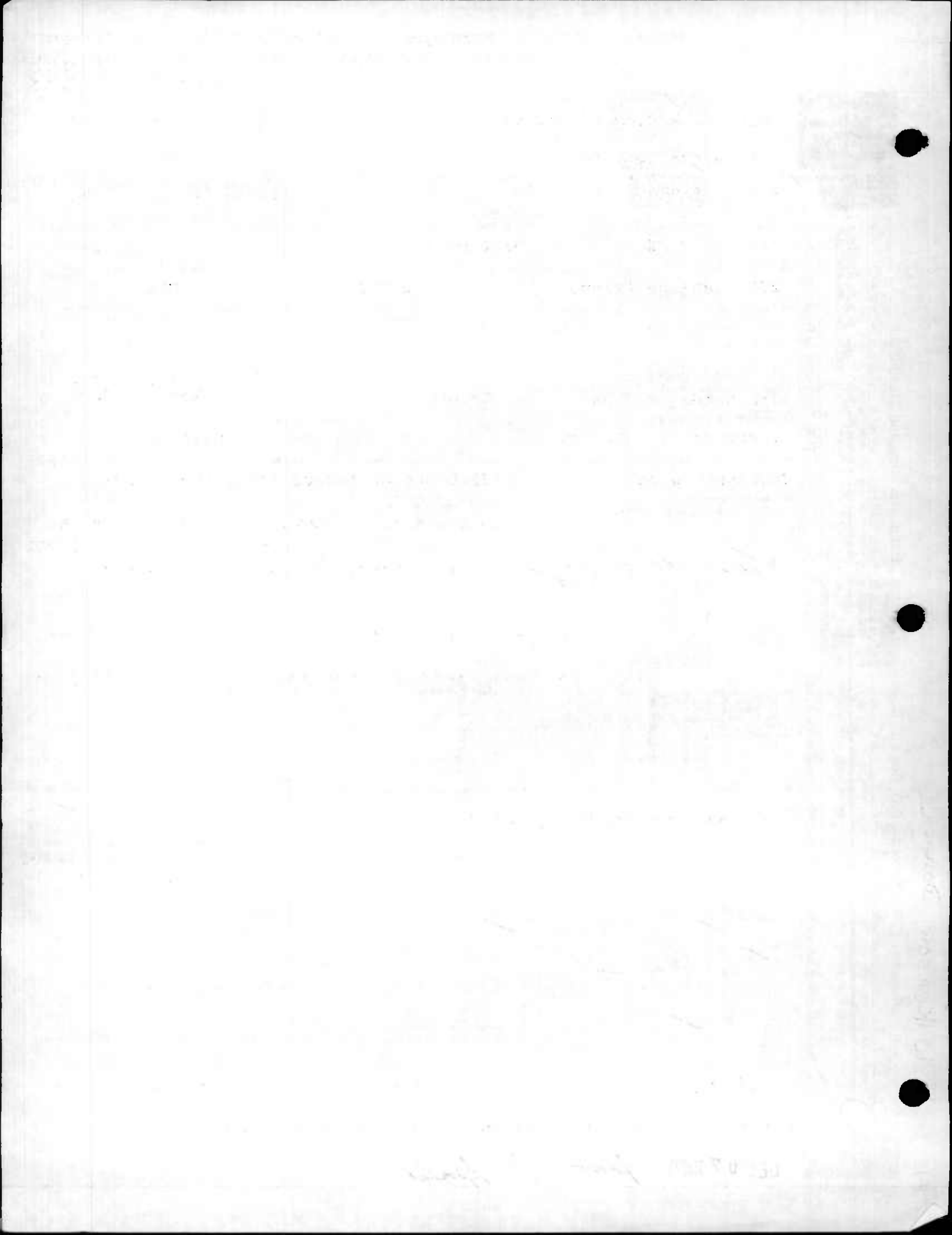
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38350

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IM KYUN WOO

2. Date of Death

Month Day Year
DEC 3 1999

3. Time of Death

7:20 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH - OVERLEA

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

—

5. Social Security Number

332-62-6152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 14, 1930

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10a. State

MD

10b. County

—

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5220 YORK RD.

APT 6 H

21212

10f. Zip Code

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

CHUNG HWAN

WOO

18. Mother's Name (First, Middle, Maiden Surname)

SSI

LEE

19a. Informant's Name/Relationship (Type, Print)

RICHARD KIM, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8808 DEARBORN DR. BALTIMORE, MD. 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GONS.

Date

DEC. 6 1999

20c. Location - City or Town, State

TIMONIUM, MD

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS FUNERAL CHAPEL

235 YORK RD. TIMONIUM, MD. 21093

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARCINOMA OF PANCREAS

Approximate Interval Between Onset and Death

3 mo.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Krista S. Wells MD

29c. License number

D08344

29d. Date signed (Month, Day, Year)

12/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5714 HARBOR RD, BALTO. MD 21214

31. Date filed (Month, Day, Year)

DEC 7 1999

32. Registrar's Signature

Krista S. Wells

State
Registrar

Baltimore, Maryland 21215-0020

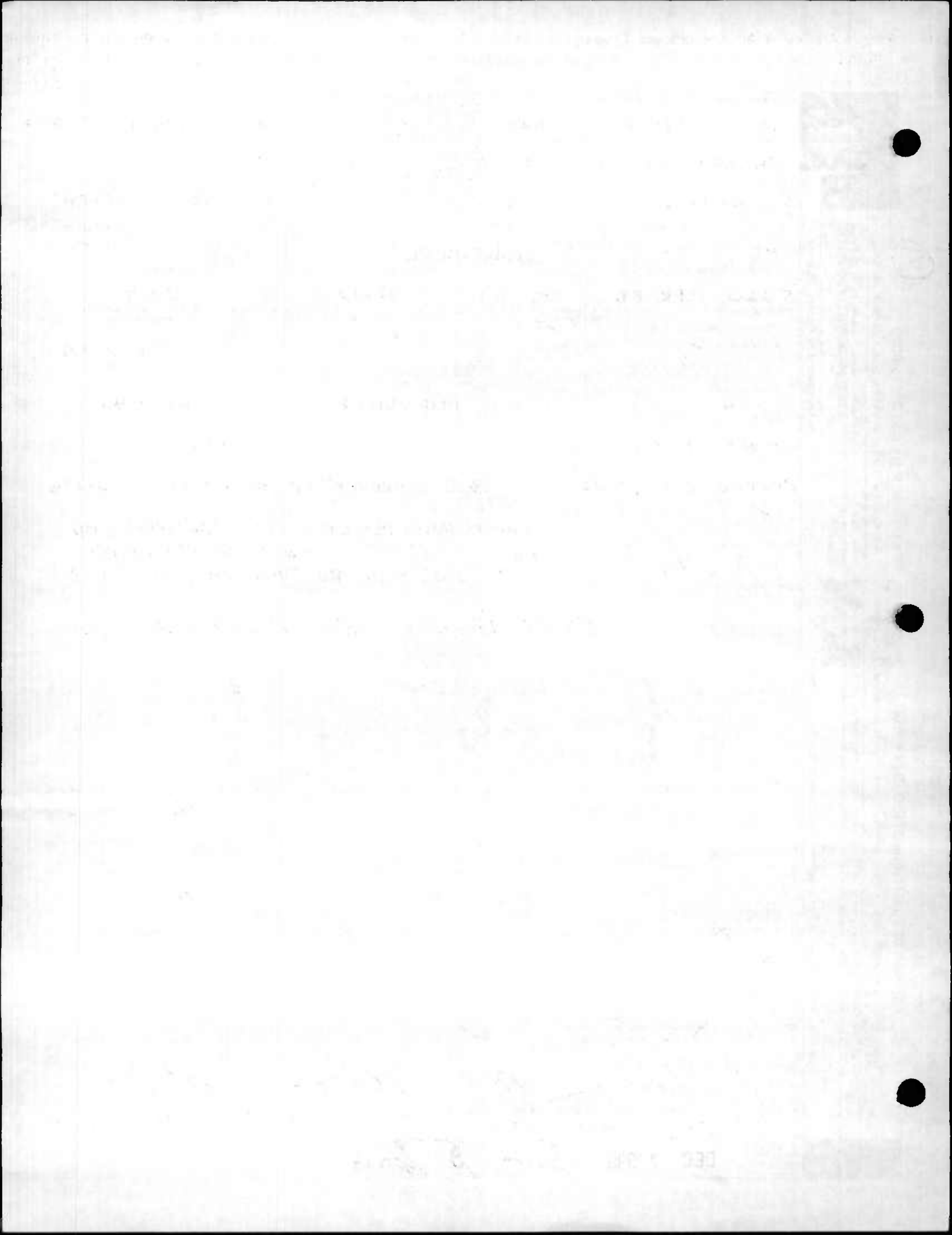
Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5050.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38351

| | | | | | | | | |
|---|---|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Timothy Williams | | | | 2. Date of Death Month Day Year DEC. 1, 1999 | | 3. Time of Death 0542 AM | |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 218-74-5051 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 36 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 02-11-63 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2639 Cecil Avenue | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction | | 16b. Kind of Business/Industry Construction Co. | | |
| 17. Father's Name (First, Middle, Last) Edward L. Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Raye | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Annie R. Williams | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 2639 Cecil Avenue Baltimore, Maryland | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kings Mem. PK. Cem. | | Date 12-07-99 | | 20c. Location - City or Town, State Randallstown, MD | | |
| 21. Signature of Funeral Service Licensee <i>Bernard D. Johnson</i> | | | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stab Wound of Chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 12-1-99 | | 28b. Time of Injury 440A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred subject stabbed | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1529 Homestead Ave Baltimore, Md | | | | |
| 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Dennis J. Chute</i> | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 2, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature <i>Bernard D. Johnson</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be ascertained within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 8 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38352

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSEPHINE TOULA WEBER | | | | 2. Date of Death Month Day Year Dec. 2, 1999 | | 3. Time of Death 3:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 9220 Smith Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-03-6753 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 6, 1920 | |
| | 9. Birthplace (State or Foreign Country) Alabama | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore County | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 9220 Smith Avenue | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 7 yrs. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Education | | | | |
| 17. Father's Name (First, Middle, Last) Leland Lee Hubbard | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kitty Erwin | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Katherine T. Davis | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 Everton Rd. Baltimore, Maryland 21209 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bohimian National Cem. 12-4-99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier MD | | 29c. License number D37612 | | 29d. Date signed (Month, Day, Year) 12-3-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Alabarak, MD 1201 Agora Drive 201, BELAIR MD 21014 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | 32. Registrar's Signature G. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38353

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ALMA WAYSON

2. Date of Death

November 29 1999

3. Time of Death

10.45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

234-52-5508

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

4/25/1932

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3 BROADWAY AVENUE

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

LAW FIRM

17. Father's Name (First, Middle, Last)

DORSEY PRICE

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES BRICK

19a. Informant's Name/Relationship (Type, Print)

JOHN MARVIN WAYSON, SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 BROADWAY AVE., GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METRO CREMATORY

Date

12/3

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, PA
426 CRAIN HWY., SW, GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC OVARIAN CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

245149

29d. Date signed (Month, Day, Year)

NOVEMBER 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABAYO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Spade

Wayson, Mary A.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2020.

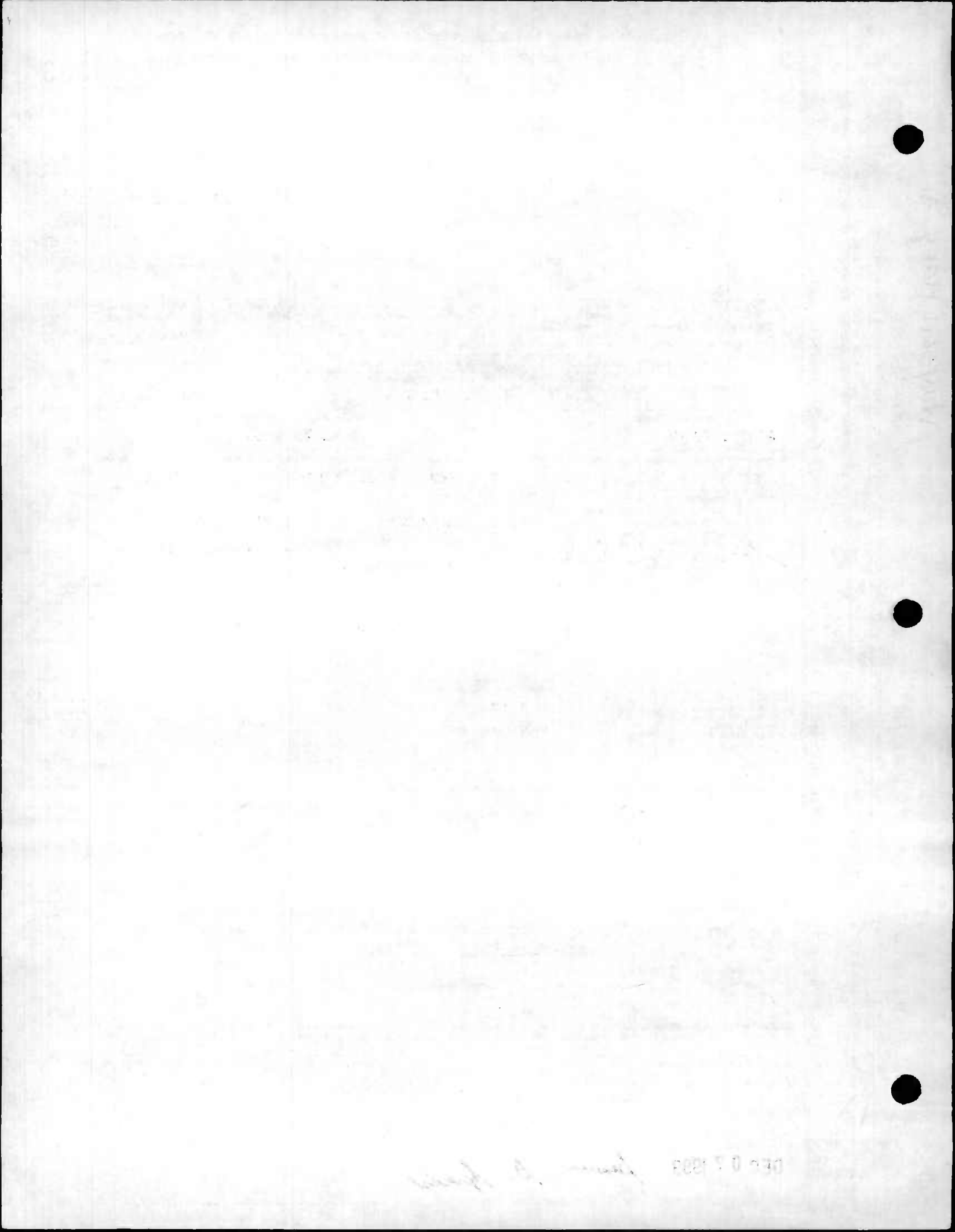
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



DEC 0 7 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38354

| | | | | | | | | | | |
|--|---|---------------------------|---|--|--|---------------------------------|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Josephine Williams | | | | | | 2. Date of Death Month 12 Day 03 Year 99 | | 3. Time of Death 4 15 PM | |
| | 4a. Facility Name (If not institution, give street and number) 1100 Pennsylvania Avenue, Apt. 712 | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-26-3438 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) 09/25/37 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 1100 PENNSYLVANIA AVENUE # 712 | | | | 10f. Zip Code 21201 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 TH GRADE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC | | | | 16b. Kind of Business/Industry HOME | | |
| 17. Father's Name (First, Middle, Last) JOSEPH BAKER | | | | 18. Mother's Name (First, Middle, Maiden Surname) CARRIE THOMAS | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ANGELUS MIXSON / COUSIN | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9508 LIBERTY RD., RANDALSTOWN, MD 21133 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS CEMETERY | | Data 12/7/99 | | 20c. Location - City or Town, State BALTO. MD | | |
| 21. Signature of Funeral Service Licensee William C. H. | | | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of Cervix Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 15 mos |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier William P. McGuire | | | | 29c. License number D16801 | | | | 29d. Date signed (Month, Day, Year) 12/6/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM PATRICK MCGUIRE, III, M.D. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature James B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

James B. Jones

DEC 1 1966

Please Type or Print in Black Indellible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38355

AMEND#23 PER F.H. G778 12-7-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE MAE WELBOURNE

2. Date of Death

Month

Day

Year

12-02-99

3. Time of Death

11 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5563 ELDERON AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

219-14-1946

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10-13-13

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5563 ELDERON AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9 TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

DOCTORS OFFICE

17. Father's Name (First, Middle, Last)

HENRY JORDAN

18. Mother's Name (First, Middle, Maiden Surname)

MARY PARKS

19a. Informant's Name/Relationship (Type, Print)

ANNIE SCOTT DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3416 MARYVALE RD. RANDALSTOWN MD. 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

12/07/99 GWYNNE OAK MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO-RESPIRATORY FAILURE

Due to (or as a consequence of):

METASTATIC VULVAR CANCER

b. Due to (or as a consequence of):

c. METASTATIC VULVAR DISEASE (CANCER)

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicidal4 ☐ Homicidal5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vaughn C. Greene

29c. License number

P11504

29d. Date signed (Month, Day, Year)

12/02/99

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

CATALIN BUIHIMSI - 225 GREENE ST BALTIMORE 21201 MD

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

B. Parks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1970

11

11/12/70

11/12/70

11/12/70

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38356

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RONNIE BUTCH WEBB

2. Date of Death

Month Day Year
DEC. 1, 1999

3. Time of Death

1:23 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

551 PALISADES BLVD.

4b. City, Town, or Location of Death

CROWNSVILLE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

218-36-0613

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 12, 1941

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROWNSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

551 PALISADES BLVD.

10f. Zip Code

21032

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: VIET NAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

CIVIL ENGINEER

16b. Kind of Business/Industry

ARMY CORP OF
ENGINEERS

17. Father's Name (First, Middle, Last)

BROOKS W. WEBB

18. Mother's Name (First, Middle, Maiden Surname)

STELLA CERRE

19a. Informant's Name/Relationship (Type, Print)

BARBARA A. WEBB / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

551 PALISADES BLVD., CROWNSVILLE, MD 21032

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
METRO CREMATORY, INC.

Date

DEC. 1
1999

20c. Location - City or Town, State

CATONSVILLE, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC MALIGNANT MELANOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D16364

29d. Date signed (Month, Day, Year)

12/1/99


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER R. GRAZE, M.D., 900 BESTGATE RD., SUITE 300, ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature


State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Items #15, 21, 22 per FH G778 12/13/99 EW

Certificate of Death

Reg. No.

99 38357

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Donald G. Yingling

2. Date of Death
Month Day Year
Nov 23 993. Time of Death
18-05

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital 900 S. Caton Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-30-1536

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sep 16, 1933

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

820 S. Caton Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9 unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Fred Yingling

18. Mother's Name (First, Middle, Maiden Surname)

Dora Butler

19a. Informant's Name/Relationship (Type, Print)

Fred Yingling/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/3/99

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

Bernard DaBrowski

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Gary L. Kaufman Funeral Home
Washington Blvd, Elkridge MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Carcinoma of Lung

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 mo

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
Atrial fibrillation
Emphysema

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Berkar

29c. License number

D21649

29d. Date signed (Month, Day, Year)

Nov 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. BASKIN, 3455 Wilkens Av. Baltimore MD 21229

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

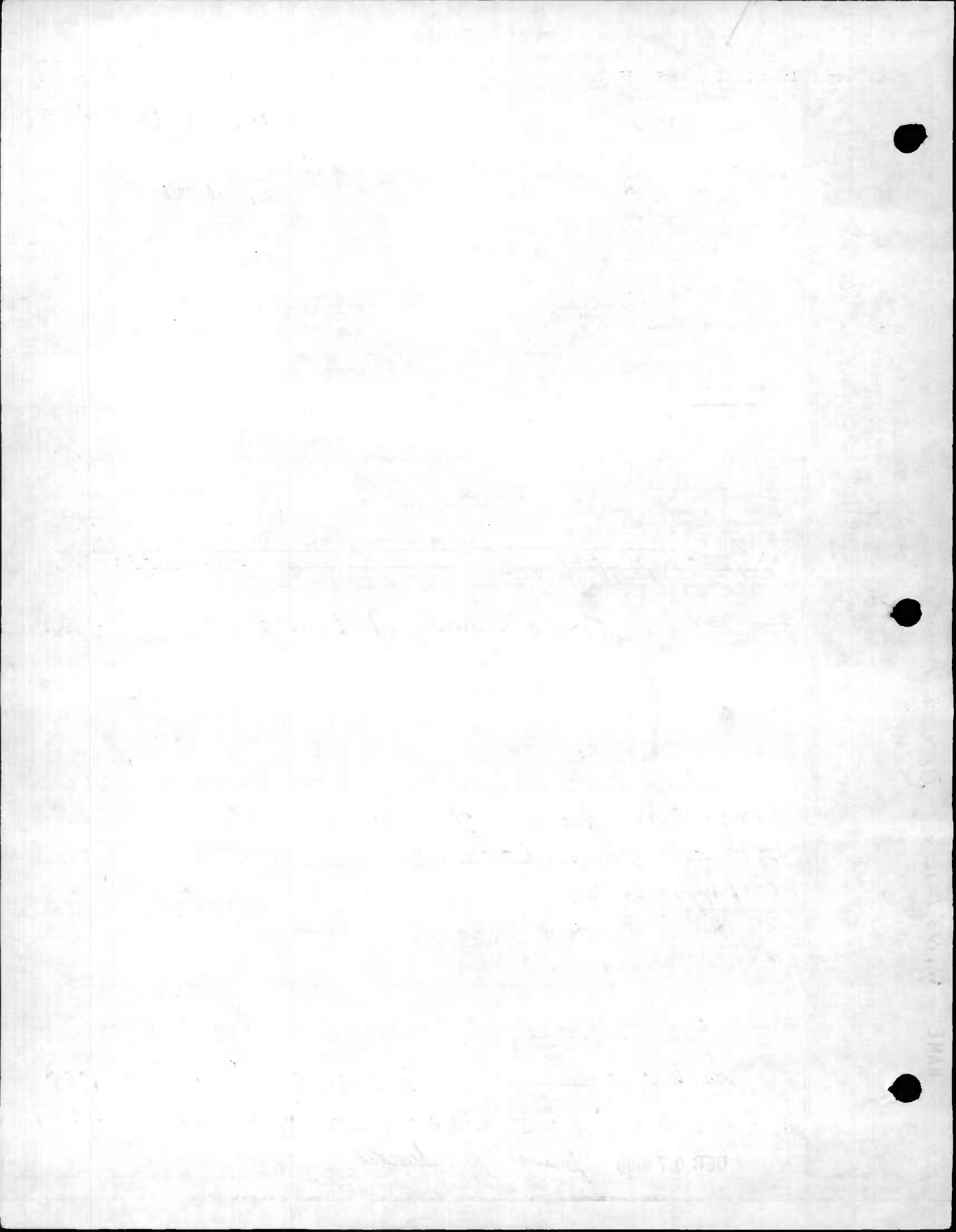
NAME

AH

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

NATARSHA YARBROUGH

amend item 23a, 27, 28a, b, c, d, e, f

G780 2/23/00 vg

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38358

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Natarsha K. Yarbrough

2. Date of Death

Month Day Year
DECEMBER 2, 1999

3. Time of Death

0735 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

212-55-6785

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

9 5

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03-07-99

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

722 East North Avenue

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Infant

College (1-4 or 5+)

Infant

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Child

16b. Kind of Business/Industry

Child

17. Father's Name (First, Middle, Last)

Leslie O. Yarbrough, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Taura King

19a. Informant's Name/Relationship (Type, Print)

Darlene King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

722 E. North Avenue Baltimore, Maryland

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Zion Cemetery 12-08-99

Data

20c. Location - City or Town, State

Lansdowne, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

BALTIMORE, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. POSITIONAL ASPHYXIA COMPLICATING BRONCHIOLITIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ NoHospital: ☐ Inpatient ☒ Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural☒ Accident☐ Suicide☐ Homicide5. Pending
investigation6. Could not be
determined

28a. Date of Injury

(Month, Day Year)

12/2/1999

28b. Time of

Injury

7:00

28c. Injury at

Work?

☐ Yes ☒ No28d. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Residence

28e. Describe how injury occurred
subject
overlaid by another
sibling while sleeping28f. Location (Street and Number or Rural Route Number,
City or Town, State) 722 E. North
Ave., Baltimore, Md.29a. Certifier
(Check only
one)☐ Certifying Physician☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 3, 1999

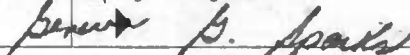
30. Name and address of person who completed cause of death (Form 23a) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 07 1999

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2024.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 6 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38359

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | |
|---|--|---|---|---|--------------------------------|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Rose Finkelstein Zall | | | | | | 2. Date of Death Month Day Year December 6 1999 | | | 3. Time of Death 6:00 am | |
| 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington | | | | | | 4b. City, Town, or Location of Death Rockville | | | 4c. County of Death Montgomery | |
| 5. Social Security Number 220-38-5084 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 5, 1907 | | 9. Birthplace (State or Foreign Country) Russia | | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 6121 Montrose Road | | | | 10f. Zip Code 20852-4856 | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Abraham Finkelstein | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Toba Unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Resa Jascourt (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Maplewood Court, Greenbelt, MD 20770 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kneseth Israel Cemetery | | Date 12/08 | | 20c. Location - City or Town, State Annapolis, MD | | | |
| 21. Signature of Funeral Service Licensee <i>Michael P. Ketta</i> | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Basal cell carcinoma of face</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Gay B. Hill MD</i> | | | 29c. License number D0055258 | | 29d. Date signed (Month, Day, Year) December 6, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY WILKS, MD Hebrew Home 6121 Montrose Road Rockville, Maryland 20852 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 07 1999 | | | | 32. Registrar's Signature <i>Beverly B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38360

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kamonte Raquom Adams | | | | 2. Date of Death Month Day Year DECEMBER 02 1999 | | 3. Time of Death 6:44 A | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 220-55-6827 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 1 6 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 10/27/1999 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 3025 Oakley Ave. | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry None | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Michael Adams | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kenyel Ward | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Kenyel Ward / Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3025 Oakley Ave. Baltimore, Maryland 21215 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park Cem. | | 20c. Location - City or Town, State 12-11-99 12/09/99 Woodlawn, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUDDEN INFANT DEATH SYNDROME (SIDS) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Theodore M. King MD | | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DECEMBER 02, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2028.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



99 38361

ORIGINAL

1714

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 08 1933
H. J. Brown

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38362
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Clement Andrews

2. Date of Death
Month Day Year

December 6 1999 12:01 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

215 09 9310

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

8. Data of Birth (Month, Day, Year)

Oct. 25, 1915 Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25 Cockpit Street

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Frieght Company

17. Father's Name (First, Middle, Last)

Anthony Andruckiewicz

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Cybulska

19a. Informant's Name/Relationship (Type, Print)

William Adkins (step son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Cockpit Street Middle River, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Rosary Cemetery 12/9/1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

b. Hemolytic Anemia

Due to (or as a consequence of):

c. Lymphoma

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute myocardial Infarction,

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signatura and title of certifier

[Signature] MD

29c. License number

D40819

29d. Date signed (Month, Day, Year)

December 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Marco A. Zamora 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signatura

[Signature]

State
Registrar

Andrews, Peter - Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

AH

SECRET

DEC 8 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38363

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRENDA

BERRY

2. Date of Death

Month

Day

Year

DECEMBER

5

1999

3. Time of Death

14:00

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

212-48-0313

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

01/13/1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1828 Bethel St.

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laundry Worker

16b. Kind of Business/Industry

Laundry

17. Father's Name (First, Middle, Last)

James Thrower

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Widgeon

19a. Informant's Name/Relationship (Type, Print)

Linda Budd / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3137 Clifftmont Ave., Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King Memorial Park Cem.

Date

12/10/00

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Derrick C. Jones Funeral Home

4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hyperthyroidism

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

b. hypertension

Due to (or as a consequence of):

5 years

c. atherosclerotic heart disease

Due to (or as a consequence of):

2 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

REB-000

29d. Date signed (Month, Day, Year)

December 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doree Chatterjee, 600 N. Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38364
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George R. Barnes

2. Date of Death
Month Day Year
December 05, 19993. Time of Death
3:32 P.M.

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-82-8422

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 14, 1970

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2117 Mt. Holly Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Car Detailing Shop

17. Father's Name (First, Middle, Last)

George Garbo

18. Mother's Name (First, Middle, Maiden Surname)

Joan R. Barnes

19a. Informant's Name/Relationship (Type, Print)

Eloise Barnes grandmother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2117 Mt. Holly Street Baltimore, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial

Date

12/11/99

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1038 N. Guilford St. Baltimore, Maryland 21201
Robert & Wayne Funeral Home PA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple gunshot wounds

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

12-5-99

28b. Time of Injury

12:48 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Gunshot wound

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

CAR

28f. Location (Street and Number or Rural Route Number, City or Town, State)

500 BLK DOWELL ST. BALTIMORE MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 07, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARRIS A. KOSCH MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

ORIGINAL

DEC 08 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38365

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Cecelia Blackmon

2. Date of Death

Month Day Year
DECEMBER 5, 1999

3. Time of Death

0800

4a. Facility Name (If not institution, give street and number)

Deaton VMMS

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-16-8792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-29-22

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1027 Cathedral Street Apt. 5-L

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9th Grade

College (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Clarence Freeman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rose Jackson Freeman

19a. Informant's Name/Relationship (Type, Print)

Carleane V. Thompson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 West Conway St. Apt. 1204 Baltimore, MD 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Calvary Cemetery

Date

12-09-99 Anne Arundel Co, MD.

21. Signature of Funeral Service Licensee

Alvin H. Davis

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiac arrhythmia*

Due to (or as a consequence of):

4 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *atherosclerotic heart disease*

Due to (or as a consequence of):

10 hrs

c. *congestive heart failure*

Due to (or as a consequence of):

5 hrs

d. *hypertension*

15 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 30494

29d. Date signed (Month, Day, Year)

12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deaton Medical Center 611 south charles st Baltimore MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Jane Blackmon

A14

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38366

| | | | | | | | | | | | | | | | |
|--|--|---------------------------|---|---|--|--|--------------------------------|--|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM C. BRIDDELL, JR. | | | | 2. Date of Death Month November Day 30 Year 1999 | | | | 3. Time of Death 16:43 P.M. | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | | | | | | |
| Funeral Director | 5. Social Security Number 225-32-8388 | | 6. Sex XX M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 11-14-1925 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | | | 10d. Inside City Limits XX Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 110 WEST 39th. STREET | | | | 10f. Zip Code 21210 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed XX Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes XX No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes XX No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES REPRESENTATIVE | | | | 16b. Kind of Business/Industry CHANG & CABLE CO. | | | | | | | |
| 17. Father's Name (First, Middle, Last) WILLIAM CRESTON BRIDDELL, SR. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MINNIE MCGEE | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN D. BRIDDELL (BROTHER) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2921 TAPPS TURN, BLOOMINGTON, INDIANA, 47401 | | | | | | | | | |
| 20a. Method of Disposition XX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK CEMETERY 12-3 WOODLAWN, MD., 21207 | | | | Date | | 20c. Location - City or Town, State | | | | | |
| 21. Signature of Funeral Service Licensee R. G. Rutt | | | | | | 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Gastrointestinal Bleed Due to (or as a consequence of): c. Peptic Ulcer Disease Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 8 days 8 days 3 days | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Michelle Collins, M.D. | | | | 29c. License number AT2438946 | | | | 29d. Date signed (Month, Day, Year) November 30, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michelle Collins, M.D. 201 East University Parkway, MD 21218 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38367

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MATILDA W. BRAMBLE

2. Date of Death
Month Day Year
DEC. 01 19993. Time of Death
11:15AM

4a. Facility Name (If not institution, give street and number)

WESLEY HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-46-5555

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
07/31/1901

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

211 WEST ROGERS AVE

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5YRS

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

WILLIAM GOVER WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MARY LOUISE CECIL

19a. Informant's Name/Relationship (Type, Print)

FORREST F. BRAMBLE JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 S. CALVERT ST. BALTO., MD. 21202.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. STEPHENS CEMETERY

Date

12/6/99

20c. Location - City or Town, State

MILLERSVILLE, MD.

21. Signature of Funeral Service Licensee

William V. Jenkins

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.

4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

UROSERBIS

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

X9

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Vergara-Soares

29c. License number

D16619

29d. Date signed (Month, Day, Year)

12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. VERGARA-SOARES M.D. 2211 W. ROGERS AVE. BALTO., MD. 21209.

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2024.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

DEC 68 1050

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38368

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Blackburn, Jr.

2. Date of Death

Month Day Year
DEC 3 1999

3. Time of Death

1:47 PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

578-36-6411

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 15, 1931

9. Birthplace (State or Foreign Country)

District of Columbia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9206 Mellenbrook Road

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1956 1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manpower Specialist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James Blackburn

18. Mother's Name (First, Middle, Maiden Surname)

Rosie Young

19a. Informant's Name/Relationship (Type, Print)

Mrs. Georgiana Blackburn Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9206 Mellenbrook Road Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veterans Cemetery

Date

12/07/99

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

► Kim Schlangue Molzogl

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic encephalopathy

Due to (or as a consequence of):

b. Cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Renal insufficiency

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Dr. Altman

29c. License number

D21461

29d. Date signed (Month, Day, Year)

Dec 3 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Perry Moore 2 Knoll North Drive Columbia MD 21045

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

Benita P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 38368.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38369

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Bell

2. Date of Death

December 4, 1999 10⁰⁰ PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

255-01-2982

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

March 1, 1917

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Georgia

10b. County

Richmond

10c. City, Town or Location

Augusta

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

712 Aumond Road

10f. Zip Code

30909

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Joseph Daniel Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sara Maude Howell

19a. Informant's Name/Relationship (Type, Print)

Howell Anne Edwards

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6048 Winter Grain Path Clarksville, Maryland 21029

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Westover Memeorial Park

Date

12/08/99

20c. Location - City or Town, State

Augusta, Georgia

21. Signature of Funeral Service Licensee

▶ [Signature] MO1204

22. Name and Address of Facility

Platt's Funeral Home, Inc.
337 N. Belair Road Evans, Georgia 30809

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic Adenocarcinoma.

Approximate Interval Between Onset and Death

1 year

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ William Flowers MD

29c. License number

V20789 -

29d. Date signed (Month, Day, Year)

December 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Flowers MD 11055 Little Patuxent Columbia MD.

State
Registrar

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-6000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38370

AMEND#6 PER F.H. G778 12-14-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Alice Katherine Burke | | | | | | 2. Date of Death Month Day Year December 2, 1999 | | 3. Time of Death 10:20PM | | | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | | | | | |
| 5. Social Security Number 216-24-8261 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) 08/04/1927 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Timonium | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 130 Hollow Brook Road | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry Archdiocese of Balto. | | | | |
| 17. Father's Name (First, Middle, Last) Edward Hart | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Molloy | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James Burke/ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Hollow Brook Road Timonium, Maryland 21093 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Cemetery | | Data 12/6/99 | | 20c. Location - City or Town, State Timonium, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D43725 | | 29d. Date signed (Month, Day, Year) 12/8/99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | 32. Registrar's Signature | | | | | | | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

ALICE BURKE December 2, 1999 10:20 p.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38371

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LARRY CORNEAL CARROLL | | | | | | 2. Date of Death Month Day Year December 05 1999 | | 3. Time of Death 03:15 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-50-4121 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 50 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 17 1949 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 4722 WRENWOOD AVENUE | | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 66/69 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12yrs College (1-4or 5+) 2yrs | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CORRECTIONAL OFFICER | | | 16b. Kind of Business/Industry CORRECTIONS | | |
| | 17. Father's Name (First, Middle, Last) JAMES JOHN CARROLL | | | | | 18. Mother's Name (First, Middle, Maiden Summa) SOPHIE HALL CARROLL | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Gloria J. Carroll/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4722 Wrenwood Avenue, Baltimore, Maryland 21212 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL | | Date 12-10 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensor <i>Barbara H. Brown</i> | | | | 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>pulmonary embolism</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 45 hours | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the causa of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>L. Jarrett Moore</i> Resident Physician | | | | 29c. License number 191965 | | 29d. Date signed (Month, Day, Year) December 05, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Jarrett Moore, M.D. 201 East University Parkway Baltimore, MD 21218 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature <i>Geneva B. Sparks</i> | | | | | | | |

CARROLL, Larry
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

44

jhm
MARK
CHANEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38372

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mark Thomas Chaney

2. Date of Death
Month Day Year
DECEMBER 4, 19993. Time of Death
04:04 AM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

214-72-3525

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 27, 1956

9. Birthplace (State or Foreign Country)

District of Columbia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

909 Winsap Court

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Ralph Chaney, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Emily Russell

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lynda Cross-Serio

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3931 McDowell Arbutus, Maryland 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

12/07/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

▶ *R. Russell* M01204

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Smoke Inhalation and Thermal Injuries*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DCA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

12/4/99

28b. Time of Injury

3:07 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28e. Describe how injury occurred

House Fire

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *J. Pestaner MD*

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

*Benjamin A. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

have made a list of the
names of the people who
were present at the
meeting on the 1st of
the month of June 1950

and to send

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38373

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Barbara Beal Bergman | | | | 2. Date of Death Month Day Year December 6, 1999 | | 3. Time of Death 1:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-48-3554 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB 1, 1929 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location College Park | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 70207 Rhode Island Avenue | | 10f. Zip Code 20740 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Addiction Counselor | | 16b. Kind of Business/Industry Counseling | | | |
| | 17. Father's Name (First, Middle, Last) James A. Beal | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cordelia Kisner Vance | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Eric A. Bergman/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 19th Street Golden, CO 80401 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Location - City or Town, State Baltimore, MD | | 20d. Date 12/7/99 | |
| | 21. Signature of Funeral Service Licensee Edward A. Gregorich | | | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myeloid Leukemia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Robert C. Irwin MD | | | | 29c. License number D08900 | | 29d. Date signed (Month, Day, Year) 12-7-99 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert C. Irwin MD 828 N. Eutam St. Bg/40 Md 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE UNIVERSITY OF CHICAGO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38374

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|---|--------------------------------|---|--|--|----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna M. Christopher | | | | | | 2. Date of Death Month Day Year December 4, 1999 | | 3. Time of Death 7:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 845 Seneca Park Road | | | | | | 4b. City, Town, or Location of Death Baltimore, | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217-07-7485 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 06/23/1910 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 845 Seneca Park Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) George Nelson French | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna May Wight | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Howard W. Christopher/ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 845 Seneca Park Road Baltimore MD 21220 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto/Wash. Crematory | | Date 12/7/99 | | 20c. Location - City or Town, State Laurel MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206 | | | | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarct Due to (or as a consequence of): b. ASN Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D0010032 | | 29d. Date signed (Month, Day, Year) 12/6/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS SEMENOV 12108 CRENSHAW BLVD BALTIMORE MD 21220 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John Doe

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38375

AMEND#7 PER MD. G778 12-30-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BABY BOY DICKERSON | | | | 2. Date of Death Month Day Year November 16 1999 | | 3. Time of Death 11:40 A.M. | |
| 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| 5. Social Security Number N/A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) N/A Yrs. | | 8. Date of Birth (Month, Day, Year) Nov 16, 1999 | |
| Usual Residence of Decedent | | | | 9. Birthplace (State or Foreign Country) MD | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number Elrich Hotel | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status N/A <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nonenone | | 16b. Kind of Business/Industry none | |
| 17. Father's Name (First, Middle, Last) Thomas Edgar Dickerson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Pratt | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jacqueline Pratt/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elrich Hotel | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Extreme Prematurity Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 25 Minutes | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Michael K. Dwyer | | | | | |
| | | 29c. License number RD 196493 | | 29d. Date signed (Month, Day, Year) November 17, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Michael Dwyer 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | | | 32. Registrar's Signature [Signature] | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Baby boy Dickerson
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filled within 72 hours after death with this Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-2000.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38376

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) REVA EDERR | | | | 2. Date of Death Month Day Year DECEMBER 3, 1999 | | 3. Time of Death 5:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 212-01-0796 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7/6/1915 | 9. Birthplace (State or Foreign Country) MD. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location RANDALLSTOWN | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3700 EASTMAN ROAD | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | | 16b. Kind of Business/Industry LEGAL | |
| 17. Father's Name (First, Middle, Last) MORRIS BRAFFMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) DEBRA MINSTER | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JEANE HARKINS/ NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3557 CENTENNIAL LANE ELLICOTT CITY, MD. 21042 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH-ATIZ CHAIM | | Date 12/5/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ANOXIC ENCEPHALOPATHY Due to (or as a consequence of): b. CARDIO PULMONARY ARREST Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE HYPERTENSION DIABETES | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  K.S. RAO, M.D. | | 29c. License number 043462 | | 29d. Date signed (Month, Day, Year) DECEMBER, 3, 99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. RAO, M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

100-100000

100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38377

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0032.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) AGNES FRIEND | | | | | | 2. Date of Death Month Day Year December 6 1999 | | 3. Time of Death 1:00Am | |
| 4a. Facility Name (If not institution, give street and number) Villa St Michael N.A. | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| 5. Social Security Number 214-14-3512 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-17-1917 | | 9. Birthplace (State or Foreign Country) Un | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3773 Columbus Drive | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) NA | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | | 16b. Kind of Business/Industry Garrison Lounge | | |
| 17. Father's Name (First, Middle, Last) Curtis Brooks | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dalphine | | | |
| 19a. Informant's Name/Relationship (Type, Print) Beatrice Williams - Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3773 Columbus Drive Balto, MD 21215 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Nat Cem | | Date 12-9-99 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Blender Wane | | | | 22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Balto, MD 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dehydration Due to (or as a consequence of): b. Failure to Thrive Due to (or as a consequence of): c. Alzheimer's Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alzheimer's Disease | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gout Parkinson's Disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Wanda J. Simmons | | 29c. License number DD035674 | | 29d. Date signed (Month, Day, Year) December 6, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wanda J. Simmons - Clemmons MD 1838 Greene Tree Rd Suite 300 Balt MD 21208 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | 32. Registrar's Signature [Signature] | | | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38378

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA

FRANKLIN

2. Date of Death

Month Day Year
DECEMBER 04 1999

3. Time of Death

06.00AM

4a. Facility Name (If not Institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

Funeral
Director

5. Social Security Number

212-48-0098

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 18, 1947

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State
MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1021 Webb Court

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify African American

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Hayes Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Jones

19a. Informant's Name/Relationship (Type, Print)

Monica D. Williams daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3413 Mary Ave. #B Baltimore, MD 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Memorial

Date

12/10/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

638 N. Baltimore St. Baltimore, MD 21217

Albert P. Wylie Funeral Hm PA

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY THROMBOEMBOLISM

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNKNOWN

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

RESIDENT

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

DECEMBER 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHUAIB ABIZ LATIF JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE MD 21207

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

DEC 8 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

99 38379

| | | | | | | | | | |
|--|---|-------------------|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Victor Feaster | | | | 2. Date of Death Month Day Year December 04, 1999 | | 3. Time of Death 7:15 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 2736 The Alameda | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 214-64-4282 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 42 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12-20-56 | | |
| | 9. Birthplace (State or Foreign Country) SC | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2736 The Alameda | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade NA College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steelside | | | 16b. Kind of Business/Industry Bethlehem Steel Co. | | |
| 17. Father's Name (First, Middle, Last) Charles Feaster, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie Gore | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Bessie Feaster | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2736 The Alameda Baltimore, Maryland 21218 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. | | Date 12-10-99 | | 20c. Location - City or Town, State Owings Mills, MD | | |
| 21. Signature of Funeral Service Licensee <i>Robert R. Davis</i> | | | | 22. Name and Address of Facility | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. <u>Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hepatic Cirrhosis in association with Chronic Alcoholism</u> | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>Joseph Pestaner, M.D.</i> | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 05, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestaner</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date (Month, Day, Year) DEC 08 1999 | | | 32. Registrar's Signature <i>Anna B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-1234.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38380

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 402-383-8000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) <u>Lila Freedman</u> | | | | 2. Date of Death Month <u>12</u> Day <u>3</u> Year <u>99</u> | | | | 3. Time of Death <u>0349</u> | | | | | | | | | | | |
| 4a. Facility Name (If not institution, give street and number) <u>University of Maryland</u> | | | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | | | 4c. County of Death <u>Baltimore City</u> | | | | | | | | | |
| 5. Social Security Number <u>106-22-1518</u> | | | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>71</u> Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth <u>02/04/28</u> (Month/Day/Year) | | 9. Birthplace (State or Foreign Country) <u>NY</u> | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| 10a. State <u>FL</u> | | | | 10b. County <u>PALM</u> | | | | 10c. City, Town or Location <u>WELLINGTON</u> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number <u>929 CEDAR COVE ROAD</u> | | | | | | | | 10f. Zip Code <u>33414</u> | | | | 10g. Citizen of What Country? <u>USA</u> | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u> | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>12</u> | | | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>CONCERT PIANIST</u> | | | | 16b. Kind of Business/Industry <u>MUSIC</u> | | | | | | | |
| 17. Father's Name (First, Middle, Last) <u>NATHAN KIMMEL</u> | | | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>GOLDIE MESTER</u> | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>ARTHUR FREEDMAN/ HUSBAND</u> | | | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>929 CEDAR COVE RD. WELLINGTON, FL. 33414</u> | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MT. ARARAT CEMETERY</u> | | | | Date <u>12/5/99</u> | | | | 20c. Location - City or Town, State <u>FARMINGDALE, NY.</u> | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | | | 22. Name and Address of Facility <u>SOL LEVINSON & BROS. INC.</u> <u>8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208</u> | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | a. <u>Abdominal Sepsis</u> Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | b. <u>enteric anastomotic breakdown</u> Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | | | | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | | | | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  MD | | | | | | | | 29c. License number <u>P12487</u> | | | | 29d. Date signed (Month, Day, Year) <u>12/3/99</u> | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Craig Skinner MD University of Maryland Hospital Balt. MD 21201</u> | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>DEC 08 1999</u> | | | | 32. Registrar's Signature  | | | | | | | | | | | | | | | |

State
Registrar

DEC 08 1950
J. H. Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38381

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome M. Fick Sr.

2. Date of Death

Month Day Year
December 3, 1999

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

4232 Belmar Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-03-3444

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
04/29/1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4232 Belmar Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Fabricator

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

John M. Fick

18. Mother's Name (First, Middle, Maiden Surname)

Edith Mae Street

19a. Informant's Name/Relationship (Type, Print)

Jerome Fick Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4232 Belmar Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory, or other place)

Gardens of Faith Cemetery

Date

12/7/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the Larynx

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6/97

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCD & H/O CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. GONGON, M.D. 8114 Sandpiper Cir, Balto. Md. 21236

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1314

C. H. Smith

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

Amended Item#12 perFHG778 12/10/99 EW

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|---|--|--|--|---|---|--|--|--|------------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Jesse Gilmore | | | | 2. Date of Death Month Day Year DECEMBER 6, 1999 | | 3. Time of Death 1637 PM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) UNION MEMORIAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | | | | | | |
| Funeral Director | 5. Social Security Number 410-40-8271 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) March 20, 1929 | | | | | | |
| | 9. Birthplace (State or Foreign Country) Tennessee | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3939 Roland View Towers East #619 | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? United States | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Korean War | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Station Operator | | 16b. Kind of Business/Industry Automotive | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Franklin Gilmore | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Evans | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Matt Gilmore / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 Liberty Church Road Gray, TN 37615 | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gilmore Family Cemetery | | Date 12/10/99 | | 20c. Location - City or Town, State Rogersville, TN | | | | | | | |
| 21. Signature of Funeral Service Licensee Michael E. Canapp | | | | 22. Name and Address of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) DECEMBER 7, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

6-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38383

amend item 5 per fh G779 1/11/2000 yg

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MILDRED F. GRANSEE | | | | | | 2. Date of Death Month Day Year DECEMBER 6, 1999 | | 3. Time of Death 1:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 97 214-18-2479 | | 6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 01-24-1923 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 101 D. DUMBARTON ROAD | | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 YEARS | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CIVIL SERVANT | | | 16b. Kind of Business/Industry U.S. DEPARTMENT OF HEALTH | | | |
| | 17. Father's Name (First, Middle, Last) JOHN WILLIAM GRANSEE | | | | | 18. Mother's Name (First, Middle, Maiden Surname) JENNIE WILENSKI | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) DANIEL E. SHIPLEY (NEPHEW) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3929 CUTTY SARK ROAD, BALTIMORE, MD., 21220 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | Date 12-9 | | 20c. Location - City or Town, State PARKWOOD, MD., 21234 | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | 29c. License number D23319 | | | 29d. Date signed (Month, Day, Year) DECEMBER 7, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATHAN M. ROSENBLUM, M.D., 7600 OSLER DRIVE, TOWSON, MARYLAND, 21204 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1000 80000
A. J. Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38384

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Hedwig Gick

2. Date of Death
Month Day Year
December 5, 19993. Time of Death
9:00PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

220-07-1911

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 28, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5026 Ilchester Road

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Franklin Cugle

18. Mother's Name (First, Middle, Maiden Surname)

Mary Louise Moore

19a. Informant's Name/Relationship (Type, Print)

James M. Gick/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Pignen Point Court Queenstown, MD 21658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

12/9/99

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Road Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PUMP Failure (Heart Failure)

Due to (or as a consequence of):

b. CORONARY ARTERY INSUFFICIENCY

Due to (or as a consequence of):

c. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

d. Type 1 Diabetes Mellitus

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation & Pacemaker

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward A. Gregorchik

29c. License number

D17107

29d. Date signed (Month, Day, Year)

12/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gebreye W. RUFATZ, 10840 Little Patuxent Pkwy #302, Columbia, MD 21049

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MD LATE

AH

DEC 8 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38385

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willie

Hemphill

2. Date of Death

Month Day Year
Dec. 04, 99

3. Time of Death

9:06pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

212-22-5659

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-08-26

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

804 Wicklow Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Union Mem. Hospital

17. Father's Name (First, Middle, Last)

Charles

Hemphill

18. Mother's Name (First, Middle, Maiden Sumame)

Roxie

Unknown

19a. Informant's Name/Relationship (Type, Print)

Viva Hemphill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 Wicklow Road Baltimore, Maryland

20a. Method of Disposition

X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest VA Cem. 12-10-99 Owings Mills,

Date

20c. Location - City or Town, State MD

21. Signature of Funeral Service Licensee

Salonia M. Davis

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Bacterial pneumonia

Approximate Interval Between Onset and Death

4 hrs

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

X Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Rameshi

29c. License number

D30641

29d. Date signed (Month, Day, Year)

December 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rameshi, MD Maryland General Professional Building 821 N. Eutaw

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38386

AMENDED ITEM #1 PER FH G778 12/8/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALTERNEASE HARDWAY

2. Date of Death

Month Day Year

DECEMBER 2nd 1999

3. Time of Death

11:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

215-40-2804

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09/21/1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

620 Kahn Drive

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Human Service Aid

16b. Kind of Business/Industry

State Social Work

17. Father's Name (First, Middle, Last)

Andrew Leak

18. Mother's Name (First, Middle, Maiden Surname)

Grace Henry

19a. Informant's Name/Relationship (Type, Print)

Grace Leak / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

620 Kahn Drive Baltimore, Maryland 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Pk. Cem. 12/10/99 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Derrick C. Jones Funeral Home
4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COLON CANCER

METASTASIS TO LIVER, ANTERIOR ABDOMINAL WALL

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

HOSPITALIST

29c. License number

D42723

29d. Date signed (Month, Day, Year)

DECEMBER 2nd 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST HOSPITAL CENTER

RANDALLS TOWN
BALTIMORE

MD 21133

State
Registrar

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

10-11-1974

10-11-1974

10-11-1974

10-11-1974

10-11-1974

10-11-1974

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38387

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED HARRIS JR.

2. Date of Death

December 4 1999

3. Time of Death

2:13pm

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-64-5917

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-11-52

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2519 LOYOLA NORTHWAY

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

-12-

-4-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

PHOTOGRAPHY

16b. Kind of Business/Industry

NEWSPAPER

17. Father's Name (First, Middle, Last)

ALFRED HARRIS SR.

18. Mother's Name (First, Middle, Maiden Surname)

FLORINE BERRY

19a. Informant's Name/Relationship (Type, Print)

ALFRED HARRIS SR. (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2519 LOYOLA NORTHWAY BALTIMORE, MARYLAND 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK

Date

12-9-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Vernon R. Bailey

22. Name and Address of Facility

VERNON R. BAILEY FUNERAL SERVICE
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

sudden

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Subtle cell disease, chronic renal failure on dialysis

Cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert H. Lewis

29c. License number

D 09212

29d. Date signed (Month, Day, Year)

December 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert H. Lewis Woodlawn Methodist Church, 1838 Green Tree Rd.

State
Registrar

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Pt. known as: Alfred Harris

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

DEC 08 1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38388

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Giuseppe Guido Iacovelli

2. Date of Death

Month Day Year
DECEMBER 07, 1999

3. Time of Death

10:58 A.M.

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-40-1447

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3-09-1929

9. Birthplace (State or Foreign Country)

Foggia, Italy

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8811 Ashford Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

Michael Iacovelli

18. Mother's Name (First, Middle, Maiden Surname)

Angela Iacovelli

19a. Informant's Name/Relationship (Type, Print)

Giovanna Iacovelli-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8811 Ashford Rd. Baltimore, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

12/10/99

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

Gary R. DiGiovanni

22. Name and Address of Facility

Leonard J. Ruck Funeral Home

5305 Harford Rd. Baltimore, Md. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulseless Electrical Activity

Due to (or as a consequence of):

b. Ischemic Cardiac myopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 min

1-3 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Guarnieri, MD

29c. License number

D 38 334

29d. Date signed (Month, Day, Year)

12/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Guarnieri 6569 N. Charles ST. Baltimore, MD 21204

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

Benita B. Sparks

State Registrar

IACOVELLI, GIUSEPPE
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

A-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38389

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD FRANK JACOBS | | | | 2. Date of Death Month Day Year DEC. 04 1999 | | 3. Time of Death UNKNOWN | |
| | 4a. Facility Name (If not institution, give street and number) 549 VALE AVENUE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NIA | |
| Funeral Director | 5. Social Security Number 219-38-6609 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 58 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUGUST 26, 1941 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County NIA | | 10c. City, Town or Location BALTIMORE CITY | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 549 VALE AVENUE | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | 16b. Kind of Business/Industry JOSEPH HOCKS TRUCKING CO. | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) TROY | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROBERTS VIOLA JOHNSON | | | |
| | 19a. Informant's Name/Relationship (Type, Print) WILLIAM JOHNSON (BROTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 AMELIA AVENUE, GLEN BURNIE, MD. 21060 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location (City or Town, State) 12-09-99 LAWSOWNE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION | | | | | | | 5 minutes |
| | Due to (or as a consequence of): b. CORONARY ARTERY DISEASE | | | | | | | 5 years |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. d. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number D 36373 | | 29d. Date signed (Month, Day, Year) 12/6/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN A. CALBORNOZ 3449 WILKENS AVE #300 BALTO 21229 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 8 1999 | | | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE UNIVERSITY OF CHICAGO
LIBRARY

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1000 8 1992

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38390

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Francis Krawczel

2. Date of Death

Dec. 3, 1999

3. Time of Death

6:45PM

4a. Facility Name (If not Institution, give street and number)

8805 Eastbourne Lane

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

209-14-9542

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

76

8. Date of Birth

March 3, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8805 Eastbourne Lane

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Packing & Shipping

17. Father's Name (First, Middle, Last)

Joseph Krawczel

18. Mother's Name (First, Middle, Maiden Surname)

Mary Pielowicz

19a. Informant's Name/Relationship (Type, Print)

Frances Barnes/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8805 Eastbourne Lane, Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

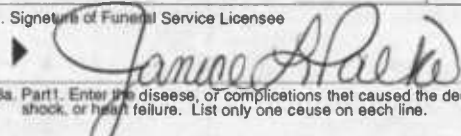
Date

12/7/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fleck Funeral Home INC, 7601 Sandy Spring Rd.,
Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocellular Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

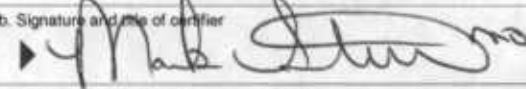
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier



29c. License number

DC17917

29d. Date signed (Month, Day, Year)

12/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Steves, MD, 110 IRVING STREET, NW, WASHINGTON, DC 20010

31. Date filed (Month, Day, Year)

DEC. 0 8 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

[Handwritten signature or initials.]

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PER MEO G 778 12-16-99 WR. **Certificate of Death**

Reg. No.

99 38391

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Nita L. Kinney | | | | 2. Date of Death Month Day Year DECEMBER 02, 1999 | | | | 3. Time of Death 23:10 PM | | | | | |
| 4a. Facility Name (If not institution, give street and number) 6 RIVERSIDE ROAD | | | | 4b. City, Town, or Location of Death Essex | | | | 4c. County of Death BALTIMORE | | | | | |
| 5. Social Security Number 215680819 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 44 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) April 3, 1955 | | 9. Birthplace (State or Foreign Country) Tennessee | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Essex | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 6 Riverside Road | | | | | | 10f. Zip Code 21221 | | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier | | | | 16b. Kind of Business/Industry Balto. Co. Govt. | | | | | |
| 17. Father's Name (First, Middle, Last) Carl Leo Maranovich | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Juanita Crounse | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carl L. Maranovich (Brother) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Riverside Road, Baltimore, Maryland 21221 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Date 12/7/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Bruzdinski Funeral HOME, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month-Day-Year) Found 12-2-99 | | 28b. Time of Injury Found 11:00 | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT RESIDENCE | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 RIVERSIDE RD ESSEX, MD | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number OCME | | | 29d. Date signed (Month, Day, Year) DECEMBER 03, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature | | | | | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38392

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTIE J. LEE | | | | 2. Date of Death Month Day Year December 7, 1999 | | 3. Time of Death 5:30am | | |
| | 4a. Facility Name (If not institution, give street and number) Bon Secure Hospital Baltimore | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | |
| Funeral Director | 5. Social Security Number 339-74-9119 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 yrs. | | 8. Date of Birth (Month, Day, Year) December 24, 1942 | | |
| | 9. Birthplace (State or Foreign Country) NC | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1645 Appleton St. | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: African American | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housing Inspector Baltimore City | | 16b. Kind of Business/Industry | | | | |
| | 17. Father's Name (First, Middle, Last) Gather Nason | | 18. Mother's Name (First, Middle, Maiden Surname) Easee Jones | | 19. Informant's Name/Relationship (Type, Print) Tyrone J. Jones Sr son | | | | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial PK | | 20c. Location - City or Town, State 12/11/99 Randalestown, MD | | 20d. Date | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility 638 N. Gilmor St. Baltimore, MD 21217 | | 22. Name and Address of Facility Robert P. Wylie Funeral Home PA | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Throat cancer with lung metastasis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 1 yr | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Mian - O Kibung, MD | | 29c. License number D31A65 | | 29d. Date signed (Month, Day, Year) 12-8-99 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mian - O Kibung Rm 206 821 N. Gilmor Street Balt Md 21201 | | 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

ORIGINAL

DEC 08 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38393

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALVIN S. LEVY

2. Date of Death

December 2, 1999

Day

Year

3. Time of Death

1510

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

213-32-7540

6. Sex

M

7. Age (In yrs. last birthday)

64

8. Date of Birth

NOV. 3 1935

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

DE.

10b. County

SUSSEX

10c. City, Town or Location

MILLVILLE

10d. Inside City Limits

1 X Yes 2 No

10e. Street and Number

5 BLACKSTONE DRIVE

10f. Zip Code

19970

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married

2 Married

3 Widowed

4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 Yes 2 No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNION VICE PRESIDENT

16b. Kind of Business/Industry

A. F. G. E.

17. Father's Name (First, Middle, Last)

SAMUEL

18. Mother's Name (First, Middle, Maiden Surname)

LEVY

19. Mother's Name (First, Middle, Maiden Surname)

ANNA

19. Mother's Name (First, Middle, Maiden Surname)

(UNKNOWN)

19e. Informant's Name/Relationship (Type, Print)

MARION LEVY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 BLACKSTONE DR. MILLVILLE, DE. 19970

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'NAI ISRAEL CONGREGATION

Date

12/5/99

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Scott M. Cullen

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.
8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Probable Pulmonary Embolus

Approximate Interval Between Onset and Death

45 mins.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
Rectal cancer

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic heart disease

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Medical Examiner

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. Kerrigan, MD

29c. License number

D44688

29d. Date signed (Month, Day, Year)

Dec. 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David C. Kerrigan, MD, 560 Riverside Dr., Salisbury, MD

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Spauls

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Handwritten signature

DEC 2 1958

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#19a PER F.H. G778 12-17-99 J.A.

Certificate of Death

Reg. No. 99 38394

| | | | | | |
|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ESTHER LEMBERGER | | 2. Date of Death Month DEC. Day 4 Year 1999 | | 3. Time of Death 6PM |
| | 4a. Facility Name (If not institution, give street and number) 3900 PINKNEY ROAD | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 134-48-0595 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 3/2/1953 | | 9. Birthplace (State or Foreign Country) NY | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County N/A |
| | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 3900 PINKNEY ROAD | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | |
| | 17. Father's Name (First, Middle, Last) JOSEPH HOFFMAN | | 18. Mother's Name (First, Middle, Maiden Surname) ILSA ADLER | | |
| | 19a. Informant's Name/Relationship (Type, Print) YITZCHOK LEMBERGER/HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 PINKNEY ROAD BALTIMORE, MD. 21215 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) AGUDATH ISRAEL OF BALTO. | | 20c. Location - City or Town, State 12/5/99 ROSEDALE, MD. |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. Hypertension failure Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. metastatic Breast Cancer Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number NB1615 | | 29d. Date signed (Month, Day, Year) December 5, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Barker 15 Walker Ave. Balto MD 21208 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

86030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38395

Baby Boy Mosley

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

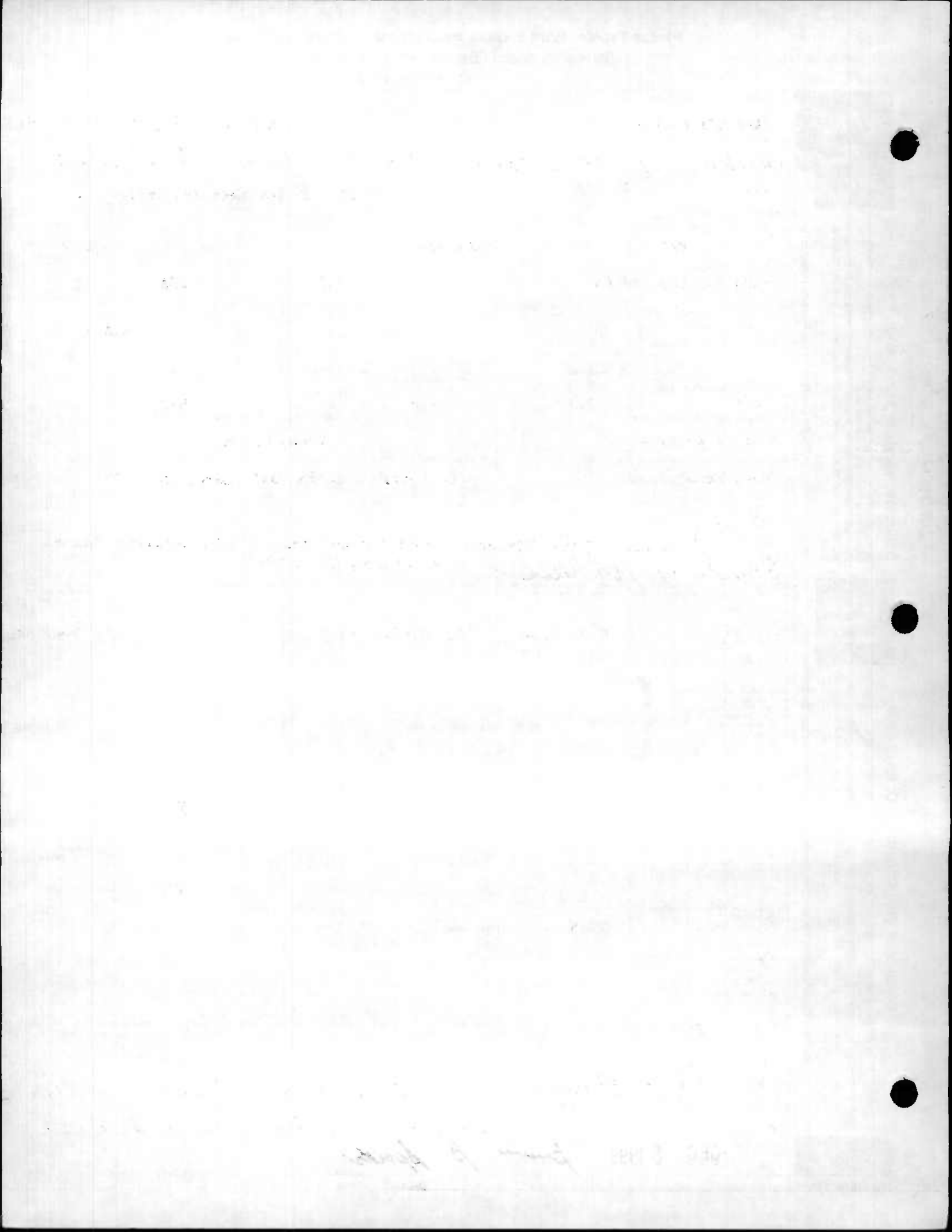
Physician /Medical Examiner

Funeral Director

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) BABY BOY MOSLEY | | | | | | 2. Date of Death Month Day Year November 29, 1999 | | 3. Time of Death 6:10 P.M. | |
| 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hospital Center | | | | | | 4b. City, Town, or Location of Death Rose Dale | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number N/A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. Months Days 03 03 | | 8. Date of Birth (Month, Day, Year) November 29, 1999 | | 9. Birthplace (State or Foreign Country) MD | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1604 Dartford Rd #A | | | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status N/A <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | | 16b. Kind of Business/Industry N/A | | |
| 17. Father's Name (First, Middle, Last) Maurice Watkins | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Penny Mosley | | | |
| 19a. Informant's Name/Relationship (Type, Print) Penny Mosely/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Dartford Rd #A Baltimore, MD 21221 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation - <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. EXTREME PREMATURITY Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | Approximate Interval Between Onset and Death 183 minutes | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | | | 29c. License number RD199026 | | 29d. Date signed (Month, Day, Year) November 29, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MICHAEL DWYER 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | | | 32. Registrar's Signature  | | | | | |

State Registrar

A-4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38396

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ELMER A MEISENHALDER JR.

2. Date of Death

DECEMBER 06, 1999

3. Time of Death

4:40 AM

4a. Facility Name (If not institution, give street and number)

1414 FUSELAGE AVENUE

4b. City, Town, or Location of Death

MIDDLE RIVER

4c. County of Death

BALTIMORE

5. Social Security Number

219-50-2714

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1948

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

MIDDLE RIVER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 DIHEDRAL DRIVE

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

ARMY 1967 to 1970

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

CHESAPE R.V. COMPANY

17. Father's Name (First, Middle, Last)

ELMER A. MEISENHOLDER SR.

18. Mother's Name (First, Middle, Maiden Surname)

ALICE ROTH

19a. Informant's Name/Relationship (Type, Print)

JEFF MEISENHOLDER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4313 RASPE AVE, BALTO. MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEMETERY

Date

12/9/99

20c. Location - City or Town, State

OWINGS MILLS MD.

21. Signature of Funeral Service Licensee

Paul M. Stella

22. Name and Address of Facility

HARTLEY MILER FUNERAL HOME CHD.

7527 HARFORD RD. BALTO MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

12/6/99

28b. Time of Injury

4:15 A

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

motor vehicle accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Fuselage Ave Baltimore Co., Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 06, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

Dennis J. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 2024.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38397

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Thomas J. Muldoon</i> | | | | 2. Date of Death Month <i>Dec</i> Day <i>5</i> Year <i>99</i> | | 3. Time of Death <i>18:50</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Columbia</i> | | 4c. County of Death <i>Howard</i> | |
| Funeral Director | 5. Social Security Number <i>016-16-7135</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>77</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>April 13, 1922</i> | |
| | 9. Birthplace (State or Foreign Country) <i>Massachusetts</i> | | 10a. State <i>Maryland</i> | | 10b. County <i>Howard</i> | | 10c. City, Town or Location <i>Ellicott City</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <i>2634 Melba Road</i> | | 10f. Zip Code <i>21042</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> <i>5+</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Sales Representative</i> | | 16b. Kind of Business/Industry <i>Steel</i> | | 17. Father's Name (First, Middle, Last) <i>James Muldoon</i> | |
| | 18. Mother's Name (First, Middle, Maiden Surname) <i>Carmen Comeau</i> | | 19a. Informant's Name/Relationship (Type, Print) <i>Mr. Kevin Muldoon Son</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10829 Henley Court Columbia, Maryland 21044</i> | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i> | | 20c. Location - City or Town, State <i>Baltimore, Maryland</i> | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> <i>MO1204</i> | | 22. Name and Address of Facility <i>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</i> | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Cardiogenic shock</i> Due to (or as a consequence of): b. <i>Ischemic cardiomyopathy</i> Due to (or as a consequence of): c. <i>Myocardial infarctions</i> Due to (or as a consequence of): d. <i>Coronary artery disease</i> | | Approximate interval Between Onset and Death <i>24 hours</i> <i>Years</i> <i>Years</i> <i>Years</i> | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | |
| | 29c. License number <i>015043</i> | | 29d. Date signed (Month, Day, Year) <i>12/6/99</i> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>11055 Little Patuxent Pkwy, Columbia, MD 21044</i> | | 31. Date (Month, Day, Year) <i>DEC 8 1999</i> | |
| State Registrar | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38398

| | | | | | | | | | | |
|--|--|-----------------------------|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John William Naumann, Sr. | | | | | | 2. Date of Death Month Day Year December 2, 1999 | | 3. Time of Death 12:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 320 Old Riverside Road | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 219-16-2496 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 73 | | 8. Date of Birth (Month, Day, Year) Sept. 13, 1926 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County Anne Arundel | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 320 Old Riverside Road | | | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Superintendant | | | 16b. Kind of Business/Industry Central Maint. Corp. | | | |
| 17. Father's Name (First, Middle, Last) John Henry Naumann | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Uttrether | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joanne Westcoat (Daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 971 Deep Creek Avenue Arnold, Maryland 21012 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery | | Date 12/4/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Kevin E. Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 | | | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Hypertension</u> Due to (or as a consequence of):</p> <p>b. <u>Severe atherosclerotic arteries</u> Due to (or as a consequence of):</p> <p>c. <u>Hyperlipidemia</u> Due to (or as a consequence of):</p> <p>d. <u>Peripheral vascular disease</u></p> | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>B/c. Coroid artery stenosis</u> | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | 29c. License number J46596 | | | 29d. Date signed (Month, Day, Year) 12/2/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 606 Hammond Lane Baltimore M.D. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | 32. Registrar's Signature | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38399

| | | | | | | | | | | |
|---|--|---------------------------|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MAUSHA NATAS | | | | 2. Date of Death Month Day Year DEC. 4 1999 | | | | 3. Time of Death 5:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-43-2443 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) 10/17/1937 | | 9. Birthplace (State or Foreign Country) LITHUANIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2922 TANEY ROAD #2C | | | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? LITHUANIA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUS DRIVER | | | | 16b. Kind of Business/Industry LIVERY | | |
| 17. Father's Name (First, Middle, Last) VULFAS NATAS | | | | 18. Mother's Name (First, Middle, Maiden Surname) KHAYA KHADUBAITE | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARIANNA KHODAB/STEP-DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 DEAVEN COURT BALTIMORE, MD. 21209 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SHOMREI EMUNAH CONG. | | Date 12/5/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC GASTRIC CARCINOMA Due to (or as a consequence of): b. WITH LIVER METASTASES, INTRA Due to (or as a consequence of): c. ABDOMINAL METASTASES AND Due to (or as a consequence of): d. SPINAL METASTASES | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D28595 | | | | 29d. Date signed (Month, Day, Year) 12/5/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM LAKHAM, 7220 PARK HEIGHTS AVE BALD MD 21208 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature  | | | | | | |

DEC 08 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38400

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sharon Louise Noppinger

2. Date of Death

Month

Day

Year

December

4

1999

3. Time of Death

0907

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

218-58-7034

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

AUG. 5, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1885 Brookside Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Ford Edward Allen

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Marie Jung

19a. Informant's Name/Relationship (Type, Print)

William Gerard Noppinger/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1885 Brookside Drive Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/6/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiomyopathy

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Cardiac arrhythmias

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dawn F. McDonald

29c. License number

D28489

29d. Date signed (Month, Day, Year)

12/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Flora H Solcal MD 206 Hays St Bel Air Md 21014

State
Registrar

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

Brenda B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Noppinger, Sharon

Handwritten signature

1981 3 0 030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND: #29D PER MD G778 12-8-99 WR.

Certificate of Death

Reg. No. 99 38401

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George Petty Jr | | 2. Date of Death Month Day Year 12 4 1999 | | 3. Time of Death 5:17 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number) 738 N. Fulton Avenue 3rd Floor | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | |
| Funeral Director | 5. Social Security Number 215-22-9945 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 4-16-1928 | |
| | 9. Birthplace (State or Foreign Country) Md | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Md | | 10b. County NA | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 738 N. Fulton Ave 3rd Floor | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U.S.A | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) NA | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer | | 16b. Kind of Business/Industry Bethlehem Steel | | |
| 17. Father's Name (First, Middle, Last) George Petty, Sr | | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Black | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Beatrice Petty-Sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 Clarks Lane Balto, Md 21215 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 12/6/99 | 20c. Location - City or Town, State Catonsville, Md | | |
| 21. Signature of Funeral Service Licensee John B. Johnson | | 22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Balto, Md 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. HTN Due to (or as a consequence of): c. Coronary artery d/s Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 328266 | | 29d. Date signed (Month, Day, Year) 12.5.99 12-6-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aye Lwin M.O. 5010 York Rd, Balto, MD 21212 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38402

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Kenneth Perry, Jr.

2. Date of Death

December 04 1999

3. Time of Death

9:15 pm

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

218-86-3713

6. Sex

XX ☐ M ☐ F

7. Age (In yrs. last birthday)

34

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03-19-65

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

303 S. Stricker Street

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

☒ Navar Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

High Sch. Grad

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Atlantic Security
Guard Inc.

17. Father's Name (First, Middle, Last)

Albert K. Perry, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Austin

19a. Informant's Name/Relationship (Type, Print)

Johnnie Mae Perry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4707 Ivanhoe Avenue Baltimore, MD. 21212

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Western Star Cemetery 12-09-99 Catonsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E.North Avenue23. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Lymphoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Acquired Immune Deficiency Syndrome
Due to (or as a consequence of):

3 years

c. Acute Renal Failure
Due to (or as a consequence of):

1 week

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicidal ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 04 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Justin C. Brown, MD Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38403

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Rebecca Peddicord

2. Date of Death

Day Year
December 2, 19993. Time of Death
11:50 PM

4a. Facility Name (If not institution, give street and number)

4485 Sheppard Lane

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

215-50-2176

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 7, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4485 Sheppard Lane

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
"UNK"

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Ira Harman

18. Mother's Name (First, Middle, Maiden Surname)

Mary Brengle

19a. Informant's Name/Relationship (Type, Print)

Mr. David Peddicord Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4485 Sheppard Lane Ellicott City, Maryland 21042

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. View Cemetery

Date

12/06/99

20c. Location - City or Town, State

Marriottsville, Maryland

21. Signature of Funeral Service Licensee

 MOOS35

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

PNEUMONIA
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

24 Hours

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

HYPERTENSION

PULMONARY HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D25547

29d. Date signed (Month, Day, Year)

December 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ervin Stanton, MD 3416 OLAMWOOD COURT, SUITE 200 OLNEY, MD 20832

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

State
Registrar

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38404

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSA E. PALMER

2. Date of Death
Month Day Year
12 - 06 - 993. Time of Death
9 26 PM

4a. Facility Name (If not institution, give street and number)

GILCHRIST NURSING HOME

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

242-54-5369

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

04-21-36

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

800 N. AUGUSTA AVENUE

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 TH GRADE

College (1-4 or 5+)

6 YRS

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SURGICAL TECHNICIAN

16b. Kind of Business/Industry

HEALTH CARE

17. Father's Name (First, Middle, Last)

MERVIN SOMMERVILLE

18. Mother's Name (First, Middle, Maiden Surname)

ELVERTA MASON

19a. Informant's Name/Relationship (Type, Print)

CYNTHIA P. DAVIS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

800 N. AUGUSTA AVE., BALTO. MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

12-13-99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Vaughn C. H.

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL PIKE, BALTO. MD. 2122923e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

colon cancer

e.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

December 7, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W.A. Riley GMC 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

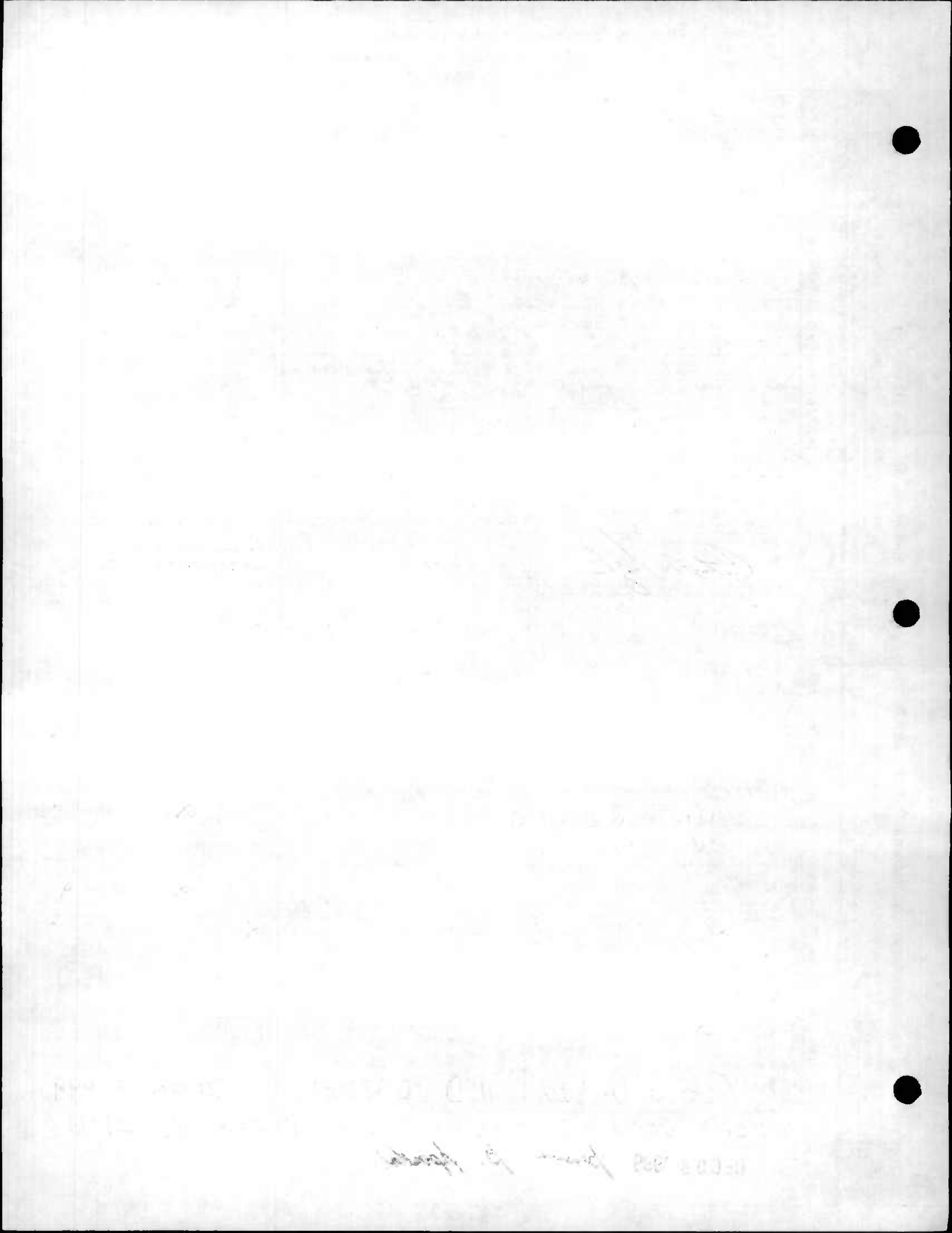
Palmer, Rosa December 6, 1999 9:26 PM
Baltimore, Maryland 21215-0020
perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 455-5555.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38405**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|-------------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Madison Parks | | | | 2. Date of Death Month Day Year December 2, 1999 | | | | 3. Time of Death 9:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 4913 Benton Heights Avenue | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-01-5317 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) 02/29/1908 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 4913 Benton Heights Avenue | | | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler | | | 16b. Kind of Business/Industry Electrical | | |
| | 17. Father's Name (First, Middle, Last) William Parks | | | | 18. Mother's Name (First, Middle, Maiden Summa) Mary Marchstein | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Edward J. Chyba | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Brett Ct. Apt. 301 Baltimore, Maryland 21221 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garden of Faith Cemetery | | Date 12/6/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 | | | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>myocardial infarction</u> Due to (or as a consequence of): b. <u>hypertension</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>refractory anemia</u> | | | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 032381 | | | 29d. Date signed (Month, Day, Year) December 3, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTORIA VANIK M.D. 3400 Brehms Lane Baltimore MD 21213 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38406

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lynn Lee Patrick

2. Date of Death

Month Day Year
December 6, 1999

3. Time of Death

8:27 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

404 42 7664

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 2, 1934

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1208 Third Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1953/55

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Industrial Machine Co.

17. Father's Name (First, Middle, Last)

William Patrick

18. Mother's Name (First, Middle, Maiden Surname)

Margie L. Morgan

19a. Informant's Name/Relationship (Type, Print)

Delores Patrick (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1208 Third Road Middle River, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Green Acres Cemetery

Date

12/10/1999

20c. Location - City or Town, State

Ermine, Kentucky

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung cancer - squamous cell

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44260

29d. Date signed (Month, Day, Year)

December 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce Kinzinger, MD 1576 Merritt Blvd Suite 14, Baltimore, MD 21222

State
Registrar

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1-28-1

[Handwritten signature]

DEC 8 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38407

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest Daniel Ray

2. Date of Death
Month Day Year

DECEMBER 05, 1999

3. Time of Death

0212 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

215-24-0783

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 4, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1125 Regina Drive

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 06/4813. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Service

17. Father's Name (First, Middle, Last)

Frank Ray

18. Mother's Name (First, Middle, Maiden Surname)

Annie Redman

19a. Informant's Name/Relationship (Type, Print)

Mary Ray (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1125 Regina Drive Arbutus, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Vet Cemetery Crownsville 12/9/99 Crownsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Sharon H. McSpiegel

22. Name and Address of Facility

Ambrose Funeral Home

1328 Sulphur Spring Road Arbutus, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Lung Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

hours

unknown

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. S. Attending Physician

29c. License number

D51854

29d. Date signed (Month, Day, Year)

December 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Silverman 900 Caton Avenue Baltimore 21229

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-1000.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.NAME Ernest Ray
Division of Vital Records, P.O. Box 68760,



WVNE

jhm
LIONEL
ROBINSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38408

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LIONEL D. ROBINSON | | | | 2. Date of Death Month Day Year DECEMBER 05, 1999 | | 3. Time of Death 00:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) 2653 MARLBORNE AVENUE | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 215-92-2260 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 23 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 2-11-1976 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2653 MARLBORNE AVE | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED | | 16b. Kind of Business/Industry RENTAL BUSINESS | | |
| 17. Father's Name (First, Middle, Last) MICHAEL ROBINSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) KAREN VAUGHAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MICHAEL ROBINSON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 GROVELAND AVE, BALTIMORE, MD 21215 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION | | Date 12-10-99 | | 20c. Location - City or Town, State MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility 4600 LIBERTY HIGHWAY AVE BALTIMORE, MD 21209. HOWELL FUNERAL HOME | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds to Chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12/5/99 Found | | 28b. Time of Injury (Hour, Minute) 12:37 PM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred Subject Shot | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Yard; Rear of 2653 Marlborne Ave; Baltimore, MD | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) DECEMBER 05, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestauer 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38409

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) HAZEL J REDDICK | | 2. Date of Death Month DECEMBER Day 7th Year 1999 | | 3. Time of Death 1:20 AM | |
| 4a. Facility Name (If not institution, give street and number) PIKESVILLE NURSING CENTER | | 4b. City, Town, or Location of Death PIKESVILLE | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 214-26-4590 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | |
| 8. Date of Birth (Month, Day, Year) OCT. 24, 1925 | | 9. Birthplace (State or Foreign Country) NORTH CAROLINA | | | |
| Usual Residence of Decedent | | 10a. State MARYLAND | | 10b. County N/A | |
| 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 727 DRUID PARK LAKE DRIVE | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: X | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Afro-AMERICAN | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) N/A | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING ASSISTANT | |
| 16b. Kind of Business/Industry ROSEWOOD STATE HOSP. | | 17. Father's Name (First, Middle, Last) ERNEST HARDY | | 18. Mother's Name (First, Middle, Maiden Surname) CLAUDIA CHAMBERS | |
| 19a. Informant's Name/Relationship (Type, Print) PRISCILLA SWEETS/NIECE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 ORCHARD STREET APT. 2/BALTO, MD. 21201 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM. | | 20c. Location - City or Town, State DEC. 11, 1999 BALTO, MD. | |
| 21. Signature of Funeral Service Licensee <i>Bernadine J. Scruggs</i> | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | e. RESPIRATORY FAILURE Due to (or as a consequence of): b. ASPIRATION PNEUMONIA Due to (or as a consequence of): c. CEREBROVASCULAR DISEASE Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 1 DAY 3 DAYS 1 YEAR | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier <i>J. L. L. M.D.</i> | | 29c. License number D-22609 | | 29d. Date signed (Month, Day, Year) DECEMBER 7th - 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RUBEN REIDER M.D. - 7445 FURNACE BRANCH RD - GLEN BURNIE MD 21060 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | 32. Registrar's Signature <i>Bernadine J. Scruggs</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38410

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Rubick

2. Date of Death

December 5th 1999 5:17 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bm Secours Hosp

4b. City, Town, or Location of Death

Balto.

4c. County of Death

N/A

5. Social Security Number

236-12-1996

6. Sex

1 ☒ M 2 ☐ F

Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

DEC 13, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1406 W. Baltimore Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder/Business Owner

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

George Rubick, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Drazenvich

19a. Informant's Name/Relationship (Type, Print)

Avyia Pearl Rubick/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1406 W. Baltimore Street Baltimore, MD 21223

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/10/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Road Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

one hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ER Physician

29c. License number

D38893

29d. Date signed (Month, Day, Year)

12/15/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lurch Elder 2000 West Baltimore St. Balt MD 21223

State
Registrar

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

1947-1948

Spring

Report of the
County Survey

1948

DEC 9 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38411

Amended Item#26 perPhyG778 12/08/99 EW

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Wesley Simering, Jr.

2. Date of Death

December 1, 1999

3. Time of Death

14:30

4a. Facility Name (If not institution, give street and number)

14 Elm Drive

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-03-2413

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

July 26, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Florida

10b. County

Palm Beach

10c. City, Town or Location

Lake Worth

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2201 Park Street

10f. Zip Code

33460

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Traffic Manager

16b. Kind of Business/Industry

Revere
Copper and Brass

17. Father's Name (First, Middle, Last)

Walter Wesley Simering, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Frances

19a. Informant's Name/Relationship (Type, Print)

Vickie Agro (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Elm Drive Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

12/4/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Disease to Brain
Due to (or as a consequence of): and Adrenal Glands

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Carcinoma of the lung
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 26656

29d. Date signed (Month, Day, Year)

12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge E. Calderon 4000 Annapolis Road Suite 201 Baltimore, Maryland 21227

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-516-6000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38412**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CORNELIUS SCOTT JR. | | | | 2. Date of Death Month DECEMBER Day 4 Year 1999 | | 3. Time of Death 12:42 PM | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 216-42-1492 | | 6. Sex 1 MA 2 F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT 16 1944 | |
| | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits X Yes 2 No | | 10e. Street and Number 2737 ROUND ROAD | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BELLE GROVE TIRES | | 16b. Kind of Business/Industry TRANSPORTATION | | | |
| | 17. Father's Name (First, Middle, Last) CORNELIUS SCOTT, SR. | | 18. Mother's Name (First, Middle, Maiden Surname) HATTIE HENRY | | 19a. Informant's Name/Relationship (Type, Print) Hattie Scott/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2737 Round Road, Baltimore, Maryland 21225 | |
| | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | 20c. Location - City or Town, State 12-10-99 BALTIMORE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction | | Approximate Interval Between Onset and Death 1 hour | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Congestive heart failure | | | | | | years | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Dilated Cardiomyopathy | | | | | | years | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Hypertension | | | | | | years | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown | | 24e. Was an autopsy performed? 1 Yes 2 X No | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No | | 25. Was case referred to medical examiner? 1 Yes 2 X No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | |
| 29c. License number 38543 | | 29d. Date signed (Month, Day, Year) December 4, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN H. SCOTT JR. 400 Caton Avenue Baltimore, Maryland 21229 | | 31. Date filed (Month, Day, Year) DEC 08 1999 | | |
| 32. Registrar's Signature <i>[Signature]</i> | | State Registrar | | DHHM 16 Rev 6/95 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

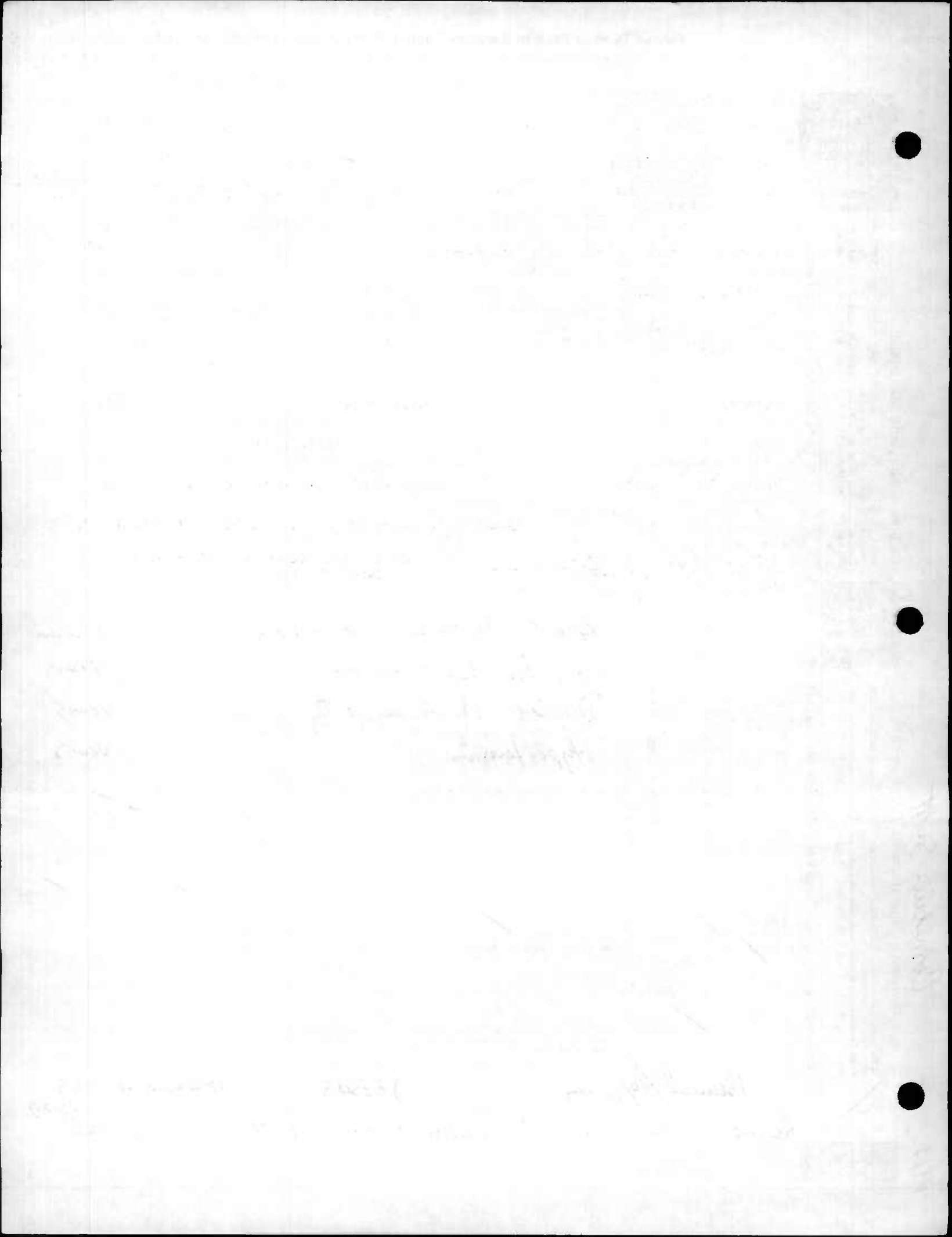
AH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #16a,b perFH G778 12/08/99 EW

Certificate of Death

Reg. No. 99 38413

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) IRENE SMITH | | | | 2. Date of Death Month Day Year DEC. 1 1999 | | 3. Time of Death 4:05AM | |
| | 4a. Facility Name (If not institution, give street and number) 1190 W. NORTHERN PARKWAY, APT. 819 | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-10-3222 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) JULY 14, 1915 | |
| | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 1190 W. NORTHERN PARKWAY, APT. 819 | | | | 10f. Zip Code 21210 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker OFFICE ADMINISTRATOR | | 16b. Kind of Business/Industry Own Home STATE OF MARYLAND | |
| | 17. Father's Name (First, Middle, Last) HERMAN GOLDSTEIN | | | | 18. Mother's Name (First, Middle, Maiden Surname) SARAH HONKOFKY | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MRS. ELAINE GAMERMAN (DAU.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7106 ROCKLAND HILLS DR. BALTIMORE, MD 21209 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL | | 20c. Location - City or Town, State BALTIMORE, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number 920604 | | 29d. Date signed (Month, Day, Year) December 1, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg, MD Suite #450, 10755 Falls Rd, Lutherville, Md 21093 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 08 1999 | | | | 32. Registrar's Signature | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

DEC 07 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38414

Amended Item#20a perFHG778 12/08/99 EW

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FRED

M.

SACHS

2. Date of Death

DEC.

3

Day

1999

Year

3. Time of Death

2AM

4a. Facility Name (If not institution, give street and number)

BRIGHTWOOD NURSING CENTER

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

216-01-2667

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAR. 19, 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2331 OLD COURT RD.#210

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

MILBROOK PARK APTS.

17. Father's Name (First, Middle, Last)

(UNKNOWN)

SACHS

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

IRENE SACHS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2331 OLD COURT RD # 210 BALTIMORE, MD. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

12/5/99

20c. Location - City or Town, State

REISTERSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Coronary Artery Disease, Arteriosclerotic

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Chronic and Acute Renal Failure

Congestive Hepatopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Arendwa

29c. License number

D17118

29d. Date signed (Month, Day, Year)

Dec 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 115 E. Melrose Ave 21212

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

THE UNIVERSITY OF CHICAGO
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LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38415

Amended Item#7 perFH G778 12/22/99 EW

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) FRANCES SCHARFMAN | | 2. Date of Death Month Day Year DEC 3 1999 | | 3. Time of Death 7:55PM | |
| 4a. Facility Name (If not institution, give street and number) 2500 W. BELVEDERE AVE. APT. 706 | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 060-34-7141 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 98 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12/10/1900 |
| 9. Birthplace (State or Foreign Country) NY | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 2500 W. BELVEDERE AVE. APT. 706 | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| 17. Father's Name (First, Middle, Last) AARON SAFFER | | | 18. Mother's Name (First, Middle, Maiden Surname) BESSIE MINTZER | | |
| 19a. Informant's Name/Relationship (Type, Print) MIRIAM ZADEK/DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5911 BONNIE VIEW DRIVE BALTIMORE, MD. 21209 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. HEBRON CEMETERY | | Date 12/5/99 | 20c. Location - City or Town, State FLUSHING, NY. |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart failure Due to (or as a consequence of): Dehydration, enteritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3d 10d | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and Title of certifier | | 29c. License number D12265 | | 29d. Date signed (Month, Day, Year) 12/4/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT ZADEK, M.D. 5911 BONNIE VIEW DR BALTIMORE, MD 21209 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature | | | |

ORIGINAL

804 30430

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38416

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|--|--|--|--|---|--------------------------------------|---|--|--|--|---|--|--|--|--------------------------|--|--|--|--|--|--|---|-----------------------------------|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM L. SPENCER | | | | 2. Date of Death Month Day Year DEC. 6, 1999 | | 3. Time of Death 4:24AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) GILCHRIST CENTER | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 214-44-1610 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) APR. 30, 1945 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 919 N. WASHINGTON ST. | | 10f. Zip Code 21205 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. AFRO-AMERICAN | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4 or 5+) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | | | 16b. Kind of Business/Industry MONARCH RUBBER CO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) WILLIAM B. SPENCER | | | | 18. Mother's Name (First, Middle, Maiden Surname) TINNIE E. HICKS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) KIM SPENCER /DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 N. PATTERSON PARK BALTO, MD. 21231 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PK. DEC. 10, 1999 BALTO, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Bernadine V. Scruggs</i> | | | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acquired immunodeficiency Syndrome Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar. as. at. au. av. aw. ax. ay. az. ba. bb. bc. bd. be. bf. bg. bh. bi. bj. bk. bl. bm. bn. bo. bp. bq. br. bs. bt. bu. bv. bw. bx. by. bz. ca. cb. cc. cd. ce. cf. cg. ch. ci. cj. ck. cl. cm. cn. co. cp. cq. cr. cs. ct. cu. cv. cw. cx. cy. cz. da. db. dc. dd. de. df. dg. dh. di. dj. dk. dl. dm. dn. do. dp. dq. dr. ds. dt. du. dv. dw. dx. dy. dz. ea. eb. ec. ed. ee. ef. eg. eh. ei. ej. ek. el. em. en. eo. ep. eq. er. es. et. eu. ev. ew. ex. ey. ez. fa. fb. fc. fd. fe. ff. fg. fh. fi. fj. fk. fl. fm. fn. fo. fp. fq. fr. fs. ft. fu. fv. fw. fx. fy. fz. ga. gb. gc. gd. ge. gf. gg. gh. gi. gj. gk. gl. gm. gn. go. gp. gq. gr. gs. gt. gu. gv. gw. gx. gy. gz. ha. hb. hc. hd. he. hf. hg. hi. hj. hk. hl. hm. hn. ho. hp. hq. hr. hs. ht. hu. hv. hw. hx. hy. hz. ia. ib. ic. id. ie. if. ig. ih. ii. ij. ik. il. im. in. io. ip. iq. ir. is. it. iu. iv. iw. ix. iy. iz. ja. jb. jc. jd. je. jf. jg. jh. ji. jj. jk. jl. jm. jn. jo. jp. jq. jr. js. jt. ju. jv. jw. jx. jy. jz. ka. kb. kc. kd. ke. kf. kg. kh. ki. kj. kl. km. kn. ko. kp. kq. kr. ks. kt. ku. kv. kw. kx. ky. kz. la. lb. lc. ld. le. lf. lg. lh. li. lj. lk. ll. lm. ln. lo. lp. lq. lr. ls. lt. lu. lv. lw. lx. ly. lz. ma. mb. mc. md. me. mf. mg. mh. mi. mj. mk. ml. mm. mn. mo. mp. mq. mr. ms. mt. mu. mv. mw. mx. my. mz. na. nb. nc. nd. ne. nf. ng. nh. ni. nj. nk. nl. nm. nn. no. np. nq. nr. ns. nt. nu. nv. nw. nx. ny. nz. oa. ob. oc. od. oe. of. og. oh. oi. oj. ok. ol. om. on. oo. op. oq. or. os. ot. ou. ov. ow. ox. oy. oz. pa. pb. pc. pd. pe. pf. pg. ph. pi. pj. pk. pl. pm. pn. po. pp. pq. pr. ps. pt. pu. pv. pw. px. py. pz. qa. qb. qc. qd. qe. qf. qg. qh. qi. qj. qk. ql. qm. qn. qo. qp. qq. qr. qs. qt. qu. qv. qw. qx. qy. qz. ra. rb. rc. rd. re. rf. rg. rh. ri. rj. rk. rl. rm. rn. ro. rp. rq. rr. rs. rt. ru. rv. rw. rx. ry. rz. sa. sb. sc. sd. se. sf. sg. sh. si. sj. sk. sl. sm. sn. so. sp. sq. sr. ss. st. su. sv. sw. sx. sy. sz. ta. tb. tc. td. te. tf. tg. th. ti. tj. tk. tl. tm. tn. to. tp. tq. tr. ts. tu. tv. tw. tx. ty. tz. ua. ub. uc. ud. ue. uf. ug. uh. ui. uj. uk. ul. um. un. uo. up. uq. ur. us. ut. uu. uv. uw. ux. uy. uz. va. vb. vc. vd. ve. vf. vg. vh. vi. vj. vk. vl. vm. vn. vo. vp. vq. vr. vs. vt. vu. vv. vw. vx. vy. vz. wa. wb. wc. wd. we. wf. wg. wh. wi. wj. wk. wl. wm. wn. wo. wp. wq. wr. ws. wt. wu. wv. ww. wx. wy. wz. xa. xb. xc. xd. xe. xf. xg. xh. xi. xj. xk. xl. xm. xn. xo. xp. xq. xr. xs. xt. xu. xv. xw. xx. xy. xz. ya. yb. yc. yd. ye. yf. yg. yh. yi. yj. yk. yl. ym. yn. yo. yp. yq. yr. ys. yt. yu. yv. yw. yx. yy. yz. za. zb. zc. zd. ze. zf. zg. zh. zi. zj. zk. zl. zm. zn. zo. zp. zq. zr. zs. zt. zu. zv. zw. zx. zy. zz. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of injury (Month, Day, Year) | | | | 28b. Time of injury M | | | | 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>W.A. Riley</i> | | | | 29c. License number 025205 | | | | 29d. Date signed (Month, Day, Year) December 6, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley 6701 N. Charles St Balto, MD 21208 | | | | 31. Date filed (Month, Day, Year) DEC 8 1999 | | | | 32. Registrar's Signature <i>Bernie Sparks</i> | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38417

| | | | | | | | | | | |
|--|--|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EUGENE SPIKES JR. | | | | | | 2. Date of Death Month Day Year DECEMBER 3, 1999 | | 3. Time of Death 0852 AM | |
| | 4a. Facility Name (If not Institution, give street and number) 1431 NORTH CAREY STREET APARTMENT # 203 | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 257-60-3660 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F X | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 9, 1940 | | 9. Birthplace (State or Foreign Country) GEORGIA | |
| | Usual Residence of Decedent | | | | | | 10c. City, Town or Location | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 1431 N. CAREY ST. APT. 203 | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. AFRO-AMERICAN | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REBAR SHOP | | 16b. Kind of Business/Industry BETHLEHEM STEEL CO. | | | |
| | 17. Father's Name (First, Middle, Last) EUGENE SPIKES, SR. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) FLORINE WHITEHEAD | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print) VALENA SPIKES/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1431 N. CAREY STREET APT. 203 BALTO, MD. 21217 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHILL MEM. GARDENS | | 20c. Location - City or Town, State DEC. 9, 1999 BALTO, MD. | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i> | | | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic Cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? Limited 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>Stephen S. Radentz</i> | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DECEMBER 3, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | 32. Registrar's Signature <i>Gene Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 8 1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38418

AMEND#5 PER F.H. G778 12-14-99 J.A.

| | | | | | | | | |
|---|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Kurt Douglas Seifert | | | | 2. Date of Death Month December Day 03 Year 1999 | | 3. Time of Death 08:47 AM. | |
| | 4a. Facility Name (If not institution, give street and number) rear of 1504 Joh Avenue / Wooded Area | | | | 4b. City, Town, or Location of Death Arbutus | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number / 346 212-88-7846 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 39 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) SEPT 30, 1960 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3652 Greenvale Road | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Metal Worker | | | 16b. Kind of Business/Industry Factory | |
| 17. Father's Name (First, Middle, Last) Nathaniel Seifert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Rossbach | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frank Seifert/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3652 Greenvale Road Baltimore, MD 21229 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | Date 12/7/99 | | 20c. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee  Thomas Gregory | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) Found 12/3/99 | | 28b. Time of Injury 0830 M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject hanged self |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  Theodore H. H. H. H. | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 4, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE H. H. H. H. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature  B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

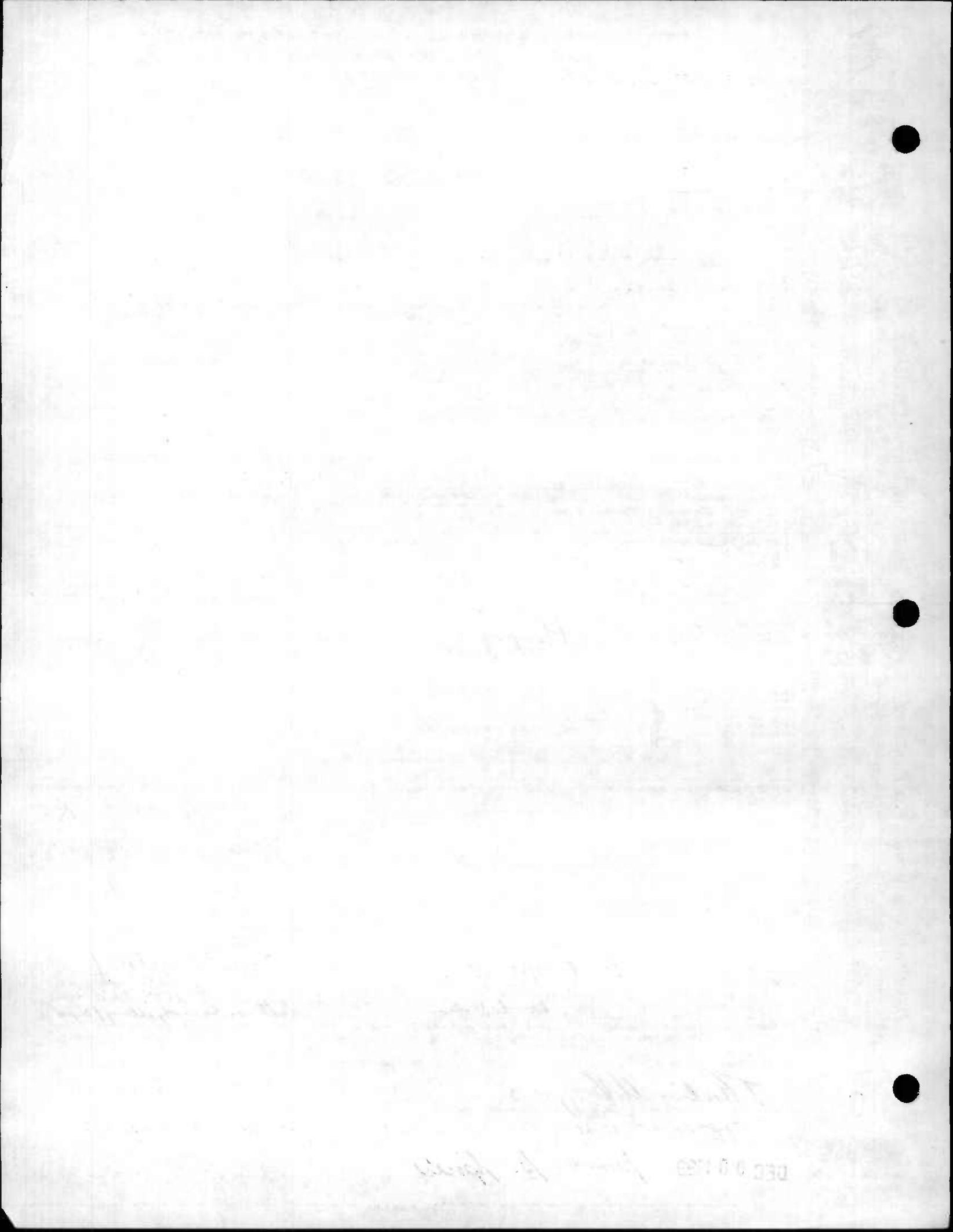
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38419

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Scholl

2. Date of Death
Month Day Year
Dec 05 19993. Time of Death
0200Funeral
Director

4e. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

313-09-4733

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

OCT 22, 1909

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

715 Maiden Choice Lane CR303

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Frederick William Scholl

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude

Unk.

19a. Informant's Name/Relationship (Type, Print)

Harriett Schaefer Scholl/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

715 Maiden Choice Lane CR303 Catonsville, MD 21228

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/6/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic prostate cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myla M. Carpenter

29c. License number

D 30989

29d. Date signed (Month, Day, Year)

Dec 05 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myla M Carpenter, MD 711 Maiden Choice Ln Catonsville MD

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

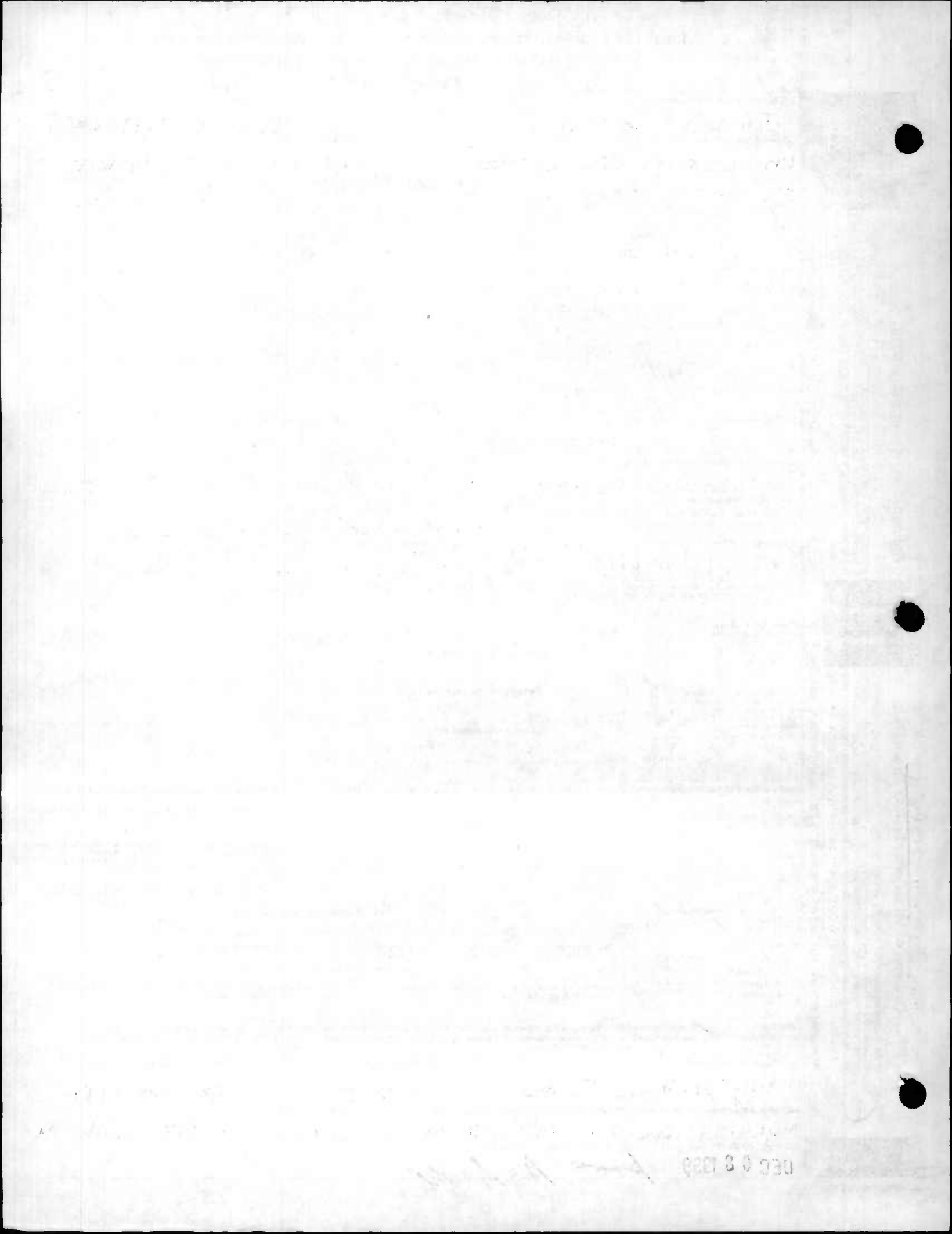
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Name: James Scholl
Division of Vital Records, P.O. Box 68760,

44



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38420

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gordon Joseph Shiloh Sr.

2. Date of Death

December 2 1999 11:25 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

214 26 3089

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 14, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

40 West Kingston Park Lane

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Welding Supervisor

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

Gordon Lester Shiloh

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Sommers

19a. Informant's Name/Relationship (Type, Print)

Deborah Corrinne Gregory (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4422 Caldwell Sq. Belcamp, Md. 21017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Mem. Gardens 12/6/1999

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis of Liver

Due to (or as a consequence of):

b. Ethanol Abuse

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Shinnars

29c. License number

D53694

29d. Date signed (Month, Day, Year)

12/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Daniel L. Shinnars, 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

Beverly S. Sparks

State Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38421

| | | | | | | | | |
|---|--|--|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Roy A. Sauer | | | | 2. Date of Death Month Day Year December 04, 1999 | | 3. Time of Death 5:15 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 834 Dorsey Avenue | | | | 4b. City, Town, or Location of Death Essex | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213 30 45 71 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) April 18, 1931 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Essex | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 834 Dorsey Avenue | | 10f. Zip Code 21221 | |
| | 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-55 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry Patapsco & Back River Railroad | |
| | 17. Father's Name (First, Middle, Last) Michael A. Sauer | | 18. Mother's Name (First, Middle, Maiden Summa) Ethel Curry | | 19a. Informant's Name/Relationship (Type, Print) Marigold Sauer (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834 Dorsey Road Essex, Maryland 21221 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens | | 20c. Location - City or Town, State Balto. Co., Maryland | | 20d. Date 12/8/99 | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Bruzdinski Funeral Home PA 1407 Old eastern Avenue Essex Maryland 21221 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral gunshot Wound of Head</i> Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <i>Requested</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) Femal 12/4/99 | | 28b. Time of Injury 1715HRS | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <i>Subject shot self</i> | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>basement stairs</i> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Essex Maryland 834 Dorsey Avenue</i> | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Theodore McKing</i> | |
| 29c. License number O.C.M.E. | | 29d. Data signed (Month, Day, Year) December 05, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE McKing</i> 111 Penn Street, Baltimore, Maryland 21201 | | 31. Data filed (Month, Day, Year) DEC 8 1999 | | |
| 32. Registrar's Signature <i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

154

Letter from the...

...

...

DEC 3 1908

Please Type or Print in Black Indelible Ink. Assure All Copies are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#19a PER INFMT. G778 12-27-99 J.A.

Certificate of Death

Reg. No. 99 38422

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Albert Ferdinand Truffer, Sr. | | 2. Date of Death Month Dec Day 8 Year 1999 | | 3. Time of Death 3:00 AM |
| 4a. Facility Name (If not institution, give street and number) 109 Oak Avenue | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore |
| 5. Social Security Number 212-44-6099 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | 8. Date of Birth (Month, Day, Year) May 5, 1945 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 109 Oak Avenue | | 10f. Zip Code 21219 | | 10g. Citizen of What Country? United States |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Gas Station | | |
| 17. Father's Name (First, Middle, Last) Ferdinand Truffer | | 18. Mother's Name (First, Middle, Maiden Surname) Madeline Fogel | | |
| 19a. Informant's Name/Relationship (Type, Print) WIFE daughter Constance Marie Truffer | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Oak Avenue, Baltimore, Maryland 21219 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | 20c. Location - City or Town, State Beltsville, Maryland |
| 21. Signature of Funeral Service Licensee Carol A. Dehn | | 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 21286 8717 Green Pastures Dr, Baltimore, MD | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Carcinoma lung Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 2 mos. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 12/8/99 | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier John D. Olsen | | 29c. License number D0018648 | | 29d. Date signed (Month, Day, Year) 12/8/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John D. Olsen 1576 Merritt Blvd Bkto MD 21222 | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature B. Sparks | | |

ORIGINAL

Handwritten signature

DEC 8 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38423

| | | | | | | | | | |
|---|---|-----------------------|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Harold F. Tillman, Sr</i> | | | | 2. Date of Death Month <i>Dec</i> Day <i>4</i> Year <i>1999</i> | | 3. Time of Death <i>6:15 AM</i> | | |
| | 4a. Facility Name (If not Institution, give street and number) <i>Levindale W.H. - Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>NA</i> | | |
| Funeral Director | 5. Social Security Number <i>219-16-6930</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>76</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>3-21-1923</i> | 9. Birthplace (State or Foreign Country) <i>Va</i> | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State <i>Md</i> | | 10b. County <i>NA</i> | | 10c. City, Town or Location <i>Baltimore</i> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <i>2207 N. Dukeland</i> | | | | 10f. Zip Code <i>21216</i> | | 10g. Citizen of What Country? <i>U.S.A</i> | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>NA</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i> | | 16b. Kind of Business/Industry <i>Bethlehem Steel</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>Phil L. Tillman</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Rosa Carter</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Paula Middleton - Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2207 N. Dukeland Street Balto, Md 21216</i> | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i> | | Date <i>12-9-99</i> | | 20c. Location - City or Town, State <i>Randallstown, Md</i> | | |
| 21. Signature of Funeral Service Licensee <i>Gladys Warner</i> | | | | 22. Name and Address of Facility <i>March West F.H. 4300 Wabash Avenue Balto, Md 21215</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Multi Infarct Dementia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>Raymond Miller MD</i> | | | | 29c. License number <i>D47683</i> | | 29d. Date signed (Month, Day, Year) <i>12/6/99</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Raymond Miller 25 Main Street Suite 200 Ruston MD</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 8 1999</i> | | | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND#23a&27 PER M.E.O. G778 12-8-99 J.A.

Reg. No.

99 384.21

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

TREVOR

NEAL

TRULLSON

2. Date of Death

Month Day Year

November 04 1999

3. Time of Death

1:17 PM.

4a. Facility Name (If not institution, give street and number)

9402 Daysville Avenue

4b. City, Town, or Location of Death

Walkersville

4c. County of Death

Frederick

5. Social Security Number

184-68-0328

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

18 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 9, 1981

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9402 Daysville Avenue

10f. Zip Code

21793

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Neal Michael Trullson

18. Mother's Name (First, Middle, Maiden Surname)

Christine Alice Cunfer

19a. Informant's Name/Relationship (Type, Print)

Neal M. Trullson / father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9402 Daysville Ave./ Walkersville, Md 21793

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resthaven Memorial Gard. 11-8-99 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home
1621 Opossumtown Pike/ Frederick, Maryland 2170223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

BRONCHIAL ASTHMA

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-1234.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38425

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Thornton

2. Date of Death

Month

Day

Year

December 4, 1999

3. Time of Death

12:43pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216.524402

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb 15, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6114 ALTA AVENUE

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

ALEXANDER JORDAN

18. Mother's Name (First, Middle, Maiden Surname)

CLARA JORDAN

19a. Informant's Name/Relationship (Type, Print)

DOROTHY MACK (DAUG)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6114 ALTA AVENUE BALTIMORE, MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

12/8/99

20c. Location - City or Town, State

WOODLAWN, MD

21. Signature of Funeral Service Licensee

Dana B. Cash

22. Name and Address of Facility

CAPLE FUNERAL SERVICE
5502 WINNER AVE BALTO, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Bradycardia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Hypoxia

Due to (or as a consequence of):

20 minutes

Myocardial Infarction

Due to (or as a consequence of):

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward B. Sidel

29c. License number

D38956

29d. Date signed (Month, Day, Year)

December 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Sidel MD, 5601 Loch Raven Blvd, Baltimore Maryland 21239-2925

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38426

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>George Udel</u> | | | | 2. Date of Death Month <u>November</u> Day <u>18</u> Year <u>1999</u> | | | | 3. Time of Death <u>12 noon</u> | |
| | 4a. Facility Name (If not Institution, give street and number) <u>Union Memorial Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number <u>215-28-1400</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>69</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>09-06-1930</u> | | 9. Birthplace (State or Foreign Country) <u>Connecticut</u> | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Baltimore</u> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number <u>103 Woodlawn Road</u> | | | | 10f. Zip Code <u>21210</u> | | | | 10g. Citizen of What Country? <u>U.S.A.</u> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> Collage (1-4or 5+) <u>4</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Media Consultant</u> | | | | 16b. Kind of Business/Industry <u>Local Media Firm</u> | | |
| 17. Father's Name (First, Middle, Last) <u>Jacob Udel</u> | | | | 18. Mother's Name (First, Middle, Maiden Summa) <u>Rose Cohen</u> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Joan Udel (WIFE)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>103 Woodlawn Rd. Baltimore, MD 21210</u> | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Baltimore Washington Cr.</u> | | 20c. Date <u>12/3</u> | | 20d. Location - City or Town, State <u>Laurel, Maryland</u> | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility <u>Fleck Funeral Home, Inc.</u> <u>7601 Sandy Spring Road, Laurel, Maryland 20707</u> <u>for Anatomic Gift Foundation</u> | | | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) <u>ACUTE RENAL FAILURE</u> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>CONGESTIVE HEART FAILURE</u> Due to (or as a consequence of): <u>HYPERKALEMIA</u> Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death <u>2 days</u> <u>10 years</u> <u>3 days</u> | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number <u>AT-2438946</u> | | 29d. Date signed (Month, Day, Year) <u>NOVEMBER 18th 1999</u> | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>MANGIA QULATI, UNION MEMORIAL HOSPITAL, EAST UNIVERSITY PARKWAY, BALTIMORE, MD.</u> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>DEC 08 1999</u> | | 32. Registrar's Signature | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 38427

AMEND#23&27-28f PER M.E.O. G778 12-21-99 J.A.

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--------------------------------|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard G. Vincent | | | | 2. Date of Death Month December Day 02 Year 1999 | | | | 3. Time of Death 01:51 PM. | |
| | 4a. Facility Name (If not institution, give street and number) Union Hospital | | | | 4b. City, Town, or Location of Death Elkton | | | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 222-50-3702 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 34 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 6, 1965 | | 9. Birthplace (State or Foreign County) Virginia | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Delaware | 10b. County New Castle | 10c. City, Town or Location Newark | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 192 North Thistle Way Glasgow Pines | | | | 10f. Zip Code 19702 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | | | 16b. Kind of Business/Industry American Frozen Foods | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Howard W. Vincent | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Koffler | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Wolfgang Vincent / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Willow Lane Middletown, DE 19709 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery | | Date 12/7/99 | | 20c. Location - City or Town, State Laurel, Delaware | | | |
| | 21. Signature of Funeral Service Licensee Timothy Harman  | | | | 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) FOUND 12-2-99 | | 28b. Time of Injury FOUND 12:41^M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred UNKNOWN | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: MOTEL ROOM | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) STEELS MOTEL, ELKTON, MD. | | | |
| | 29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 3, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. KOROLL MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 08 1999 | | 32. Registrar's Signature  | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38428

AMEND ITEM: 11PER MD G778 12-8-99 WR.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet P. Walker

JANNET WALKER

2. Date of Death

Month

Day

Year

November 28, 1999

3. Time of Death

7:10 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

243-56-5352

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02 10 40

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2818 Ruscombe Lane

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

4yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse (Lab Tech)

16b. Kind of Business/Industry

Univ of Md.

17. Father's Name (First, Middle, Last)

Howard Thorne

18. Mother's Name (First, Middle, Maiden Surname)

Emma Pullen

19a. Informant's Name/Relationship (Type, Print)

Walter Walker-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2817 Ruscombe La. Baltimore Md 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

12/03/99

20c. Location - City or Town, State

Arbutus, Md

21. Signature of Funeral Service Licensee

Shirley K Jones

22. Name and Address of Facility

March F/H West4300 Wabash Ave, Baltimore Md21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebral Herniation

Due to (or as a consequence of):

CVA

Due to (or as a consequence of):

Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shakil Khan M.D.

29c. License number

P-13206

29d. Date signed (Month, Day, Year)

November 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shakil Khan Sinai Hospital of Baltimore2401 W. Belvedere AveBaltimore, MD21215State
Registrar

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

Benjamin B Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Walker, Janet P.
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-695-2020.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38429

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BABY GIRL WILLIAMSON | | | | 2. Date of Death Month 11 Day 16 Year 99 | | 3. Time of Death 1228 | |
| 4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MED CTR | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE CITY | |
| 5. Social Security Number N/A | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) newborn Yrs. | | 8. Date of Birth (Month, Day, Year) Nov 16, 1999 | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 16 Ramfire Court | | | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status N/A <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none | | 16b. Kind of Business/Industry none | |
| 17. Father's Name (First, Middle, Last) George Williamson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Deborah Williamson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Deborah Williamson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Ramfire Ct, Owings Mills, MD 21117 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) a. SEVERE (EXTREME) PREMATURITY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Williamson NEONATOLOGY FELLOW | | | | 29c. License number D52159 | | 29d. Date signed (Month, Day, Year) 11/16/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY OF MARYLAND MEDICAL CTR | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1999 | | | | 32. Registrar's Signature P Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-6000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

THE UNIVERSITY OF MICHIGAN LIBRARY
ANN ARBOR, MICHIGAN 48106-1000

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38430

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEON

WEINER

2. Date of Death
Month Day Year

DECEMBER 2 1999 7:34 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-24-1760

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month Day Year)

1 18 1929

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2704 MAURLEEN COURT

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

XX Yes 2 ☐ No 51-53

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

PHARMACIST

16b. Kind of Business/Industry

PHARMACEUTICAL

17. Father's Name (First, Middle, Last)

ABRAHAM

WEINER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

BULMASH

19a. Informant's Name/Relationship (Type, Print)

THELMA WEINER/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2704 MAURLEEN CT. BALTIMORE, MD. 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'NAI ISRAEL CONG

Date

12/5/99

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Scott M. Gottle

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Approximate Interval Between Onset and Death

ONE WEEK

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Craig Singer, MD

29c. License number

RES-000 DECEMBER 2, 1999

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRAIG SINGER/2401 W. BELVEDERE/BALTIMORE, MD 21218

31. Date filed (Month, Day, Year)

DEC 08 1999

32. Registrar's Signature

B. Spauls

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 8 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38431

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Aveline Wozny

2. Date of Death

December 4 1999

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

9917 Whitworth Way

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

290-015-170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 11, 1918

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9917 Whitworth Way

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Anthony Ostrowski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Mrozkowski

19a. Informant's Name/Relationship (Type, Print)

Mrs. Patricia Trabbic

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9917 Whitworth Way Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

12/09/1999

20c. Location - City or Town, State

Toledo, Ohio

21. Signature of Funeral Service Licensee

Kirk Schlangel MD 201

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Complications of Hodgkin's Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 yrs

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nicholas W. Kautskas MD

29c. License number

D38509

29d. Date signed (Month, Day, Year)

December 5 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas W. Kautskas MD 11065 Little Patuxent Pky Columbia MD 21044

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38432

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wanda F. Williams

2. Date of Death

Month

Day

Year

December

5

1999

3. Time of Death

8:50 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

234 38 8803

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 12, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1207 Third Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

L.P.N. (Nurse)

16b. Kind of Business/Industry

State Hospital

17. Father's Name (First, Middle, Last)

Clifford Dawson

18. Mother's Name (First, Middle, Maiden Surname)

Nola Robinette

19a. Informant's Name/Relationship (Type, Print)

Debra Wheatley (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 Third Rd. Baltimore, Md. 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory 12/6/1999

Data

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rachel Benn Dr.

29c. License number

RD 198994

29d. Date signed (Month, Day, Year)

12/5/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. Rachel Benn, 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

Benn & Sparks

State
RegistrarWILLIAMS, Wanda Frances
Baltimore, Maryland 21215-0020

pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

A4

W. H. Packard

W. H. Packard

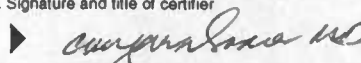
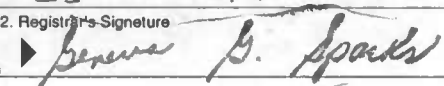
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38433

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Leoda May Zipprian | | | | | | 2. Date of Death Month December Day 6 , Year 1999 | | 3. Time of Death 1:35 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) The Wesley Home, Inc. | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 217-46-0349 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 24, 1905 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3404 Offutt Road | | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 2 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Edgar Clayton Walters | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Leoda Gertrude Belt | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joan Dunn (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Offutt Road Randallstown, MD 21133-4784 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olive Cemetery | | | Date 12/08/99 | | 20c. Location - City or Town, State Randallstown, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, MD 21133-4784 | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ASCD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier  | | | 29c. License number D 16619 | | 29d. Date signed (Month, Day, Year) 12/16/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA - SCORES 101 N. BOND ST. BALT. MD. 21231 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1999 | | | 32. Registrar's Signature  | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38434

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie Olivia Buchman

2. Date of Death

Nov. 19, 1999

3. Time of Death

6:55 P.M.

4a. Facility Name (If not institution, give street and number)

Golden Age Guest Home

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

219 22 4362

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 1, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Md.

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1449 Streaker Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Oates

18. Mother's Name (First, Middle, Maiden Surname)

Ida O. Harn

19a. Informant's Name/Relationship (Type, Print)

Gary W. Buchman (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1449 Streaker Rd. Sykesville, Md. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Park

Date

11/22/99

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home & Chapel
P.O.Box 195 Sykesville, Md. 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Chronic Atrial Fibrillation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 2 yrs

b.

Coronary Heart Failure

Due to (or as a consequence of):

> 2 yrs

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patrick Turnos, MD

29c. License number

D20806

29d. Date signed (Month, Day, Year)

11/20/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PATRICK TURNOS, MD 1425 Liberty Rd Eldersburg MD 21784

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

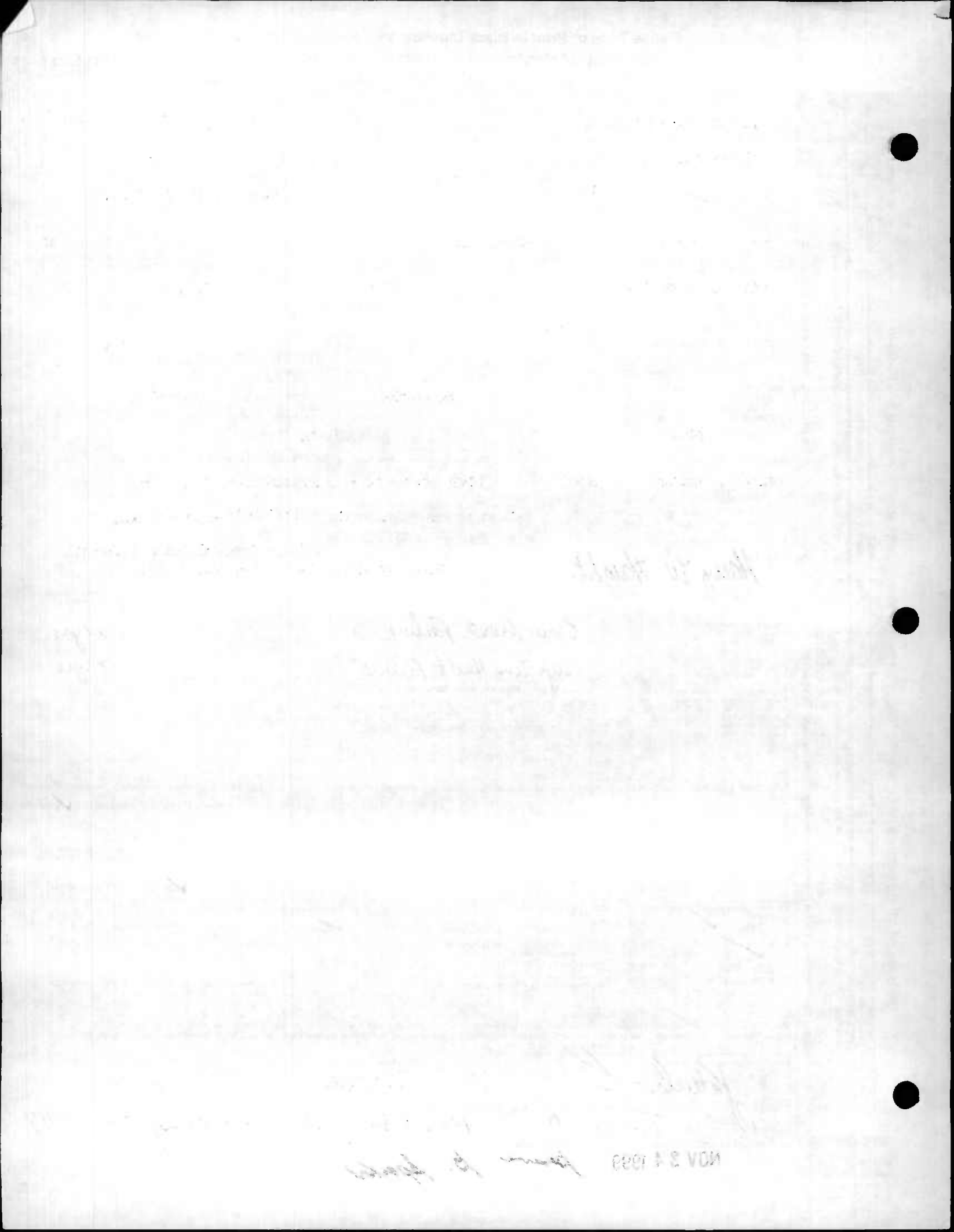
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



NOV 3 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38435

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gerald E. Boone | | | | | 2. Date of Death Month Day Year Nov 19 1999 | | | 3. Time of Death 3:15am | |
| | 4a. Facility Name (If not institution, give street and number) Westminster Nursing & Convalescent | | | | | 4b. City, Town, or Location of Death Westminster | | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 213-05-1489 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 10 1914 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1234 Washington Road | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943 1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Presser | | | 16b. Kind of Business/Industry English American Tailoring | | | |
| | 17. Father's Name (First, Middle, Last) Charles J. Boone | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lora Eyler | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Naomi M. Boone/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 727 Washington Rd Westminster, MD 21157 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery | | | Date 11/22/99 | | 20c. Location - City or Town, State Westminster, MD | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 | | | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Alzheimer's Due to (or as a consequence of): c. Dissection Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 wk 5 yr 10 yr | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier John W. Muddleton | | | | 29c. License number D25483 | | 29d. Date signed (Month, Day, Year) 11-19-1999 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Muddleton 688 Poole Rd Westminster MD 21157 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) NOV 23 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

EFFEKT VON



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38436

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Howard Benker

2. Date of Death

November 24 1999

Day Year

3. Time of Death

10:03

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

198-10-1638

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 2, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Chesapeake City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Grier Avenue

10f. Zip Code

21915

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

General Electric Inc.

17. Father's Name (First, Middle, Last)

George Benker

18. Mother's Name (First, Middle, Maiden Surname)

Rose Becker

19a. Informant's Name/Relationship (Type, Print)

Mary Anne Gustafson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

341 Hollingsworth Manor, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sts. Peter and Paul Cem. 11/30/99 Springfield, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 W. Stockton St., Elkton, MD 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Sepsis Syndrome*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ischemic cardiomyopathy
myelo dys plastic disorder
chronic renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. Bruce Obenshain, M.D.

29c. License number

00035779

29d. Date signed (Month, Day, Year)

November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Bruce Obenshain, M.D.
251 S. Bohemia Ave, Cecilton, Md. 21913

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Robert S. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38437

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Florence Brookbank | | | | 2. Date of Death Month November Day 17 , Year 1999 | | 3. Time of Death 1:27 A.M. | |
| | 4e. Facility Name (If not institution, give street and number) 7030 Old Bayside Road | | | | 4b. City, Town, or Location of Death Chesapeake Beach | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 577-22-5692 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 22, 1907 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10e. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Chesapeake Beach | |
| To Be Completed by Funeral Director | 10e. Street and Number 7030 Old Bayside Road | | 10f. Zip Code 20732 | | 10g. Citizen of What Country? USA | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper | | 16b. Kind of Business/Industry Store | | | |
| | 17. Father's Name (First, Middle, Last) Unknown | | 18. Mother's Name (First, Middle, Maiden Surname) Lottie Fletcher | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mable Hawkins/Cousin | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 363 Chesapeake Beach, MD 20732 | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | Date 11/19/99 | | 20c. Location - City or Town, State Washington, D.C. | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. chronic renal failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 6 months | | | | | | | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coronary heart failure aortic stenosis | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | |
| 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number 046314 | | 29d. Date signed (Month, Day, Year) 11/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph J. Barth, III, M.D. | | 31. Date filed (Month, Day, Year) NOV 19 1999 | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

THE UNITED STATES OF AMERICA
DOPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

11. [illegible]
12. [illegible]
13. [illegible]
14. [illegible]
15. [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38438

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILEY GROVER CARTER

2. Date of Death
Month Day Year

November 27, 1999 6:00 pm

3. Time of Death

6:00 pm

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON PRINCE GEORGES

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

435-32-5035

6. Sex

M 2 F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 10, 1925

9. Birthplace (State or Foreign Country)

LOUISIANA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

10937 BRIDLE PATH CIRCLE

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1944-
If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

BILLY CARTER

18. Mother's Name (First, Middle, Maiden Summa)

ISADELLA RIDLEY CARTER

19a. Informant's Name/Relationship (Type, Print)

MARY ROSS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10937 BRIDLE PATH CIRCLE, WALDORF, MARYLAND 20601

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHEPHERD STREET CEMETERY

Date

12/4/99

20c. Location - City or Town, State

MINDEN, LOUISIANA

21. Signature of Funeral Service Licensee

Lydia C. Thornton Johnson M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST
Due to (or as a consequence of):

b. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):

c. ASPHYXIA
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0021833

29d. Date signed (Month, Day, Year)

11-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALY SAEED, MD

11701 LIVINGSTONE RD

FORT WASH. MD. 20745

State
Registrar

31. Date filed (Month, Day, Year)

NOV 30 1999

32. Registrar's Signature

[Signature]

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wiley Carter
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #5, per F.D.
11/29/99, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

99 38439

Reg. No.

| | | | | | | | | | | | | |
|--|---|-------------------------------|---|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Louise H. Clickner | | | | | 2. Date of Death Month Nov. 19, Day 19 , Year 1999 | | | 3. Time of Death 6:10 P.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) Fairhaven Health Care Center | | | | | 4b. City, Town, or Location of Death Sykesville | | | 4c. County of Death Carroll | | | |
| Funeral Director | 5. Social Security Number 539-22-8023 530-22-8023 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | | |
| | 8. Date of Birth (Month, Day, Year) Feb. 19, 1905 | | | | | 9. Birthplace (State or Foreign Country) New Jersey | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State Md. | | 10b. County Carroll | | 10c. City, Town or Location Sykesville | | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 7200 Third Ave. | | | | | 10f. Zip Code 21784 | | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +2 | | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief Librarian | | | 16b. Kind of Business/Industry Bureau of the Censes | | | | |
| 17. Father's Name (First, Middle, Last) William Peter Hessinger | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Boyd | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. Edwin K. Clickner (Husband) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave. Sykesville, Md. 21784 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Service | | | 20c. Location - City or Town, State Sykesville, Md. | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of the esophagus Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> | | | | | | | | | | | Approximate Interval Between Onset and Death 1 month | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration Acute Renal failure | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number D22220 | | | 29d. Date signed (Month, Day, Year) November 20, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellis Mez MD 1645 Liberty Road Eldersburg, MD. 21784 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | | 32. Registrar's Signature  | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

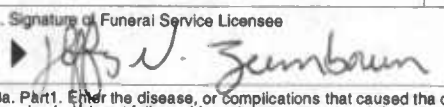
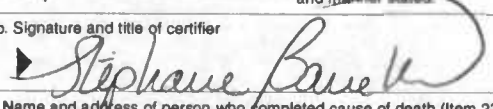
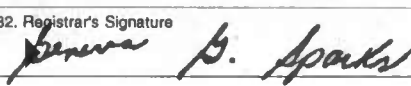
James H. Jones

NOV 2 4 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38440**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|---------------------------------|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MATTHEW RYAN CAPRIO | | | | 2. Date of Death Month NOVEMBER Day 17 Year 1999 | | | | 3. Time of Death 11:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) National Institute of Health | | | | 4b. City, Town, or Location of Death Bethesda, MD. | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 205-68-6715 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 14 Yrs. | | 8. Date of Birth (Month, Day, Year) October 6, 1985 | | 9. Birthplace (State or Foreign Country) Hanover, PA. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State PA. | | 10b. County York | | 10c. City, Town or Location Hanover | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 101 Knollwood Lane | | | | 10f. Zip Code 17331 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | | 16b. Kind of Business/Industry Education | | |
| | 17. Father's Name (First, Middle, Last) J. Paul Caprio | | | | 18. Mother's Name (First, Middle, Maiden Summa) Elizabeth Prince | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) J. Paul Caprio / Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Knollwood Lane, Hanover, PA. 17331 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Marburg Memorial Gardens | | Date 11/22/99 | | 20c. Location - City or Town, State Hanover, PA. 17331 | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Jeffrey N. Zumbrun Funeral Home 6028 Sykesville Road, Sykesville, MD. 21784 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. RECURRENT LEUKEMIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death IMMEDIATE 8 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | | | 29c. License number 94-247 (Quebec) | | 29d. Date signed (Month, Day, Year) 11/19/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHANE BARRETTE 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

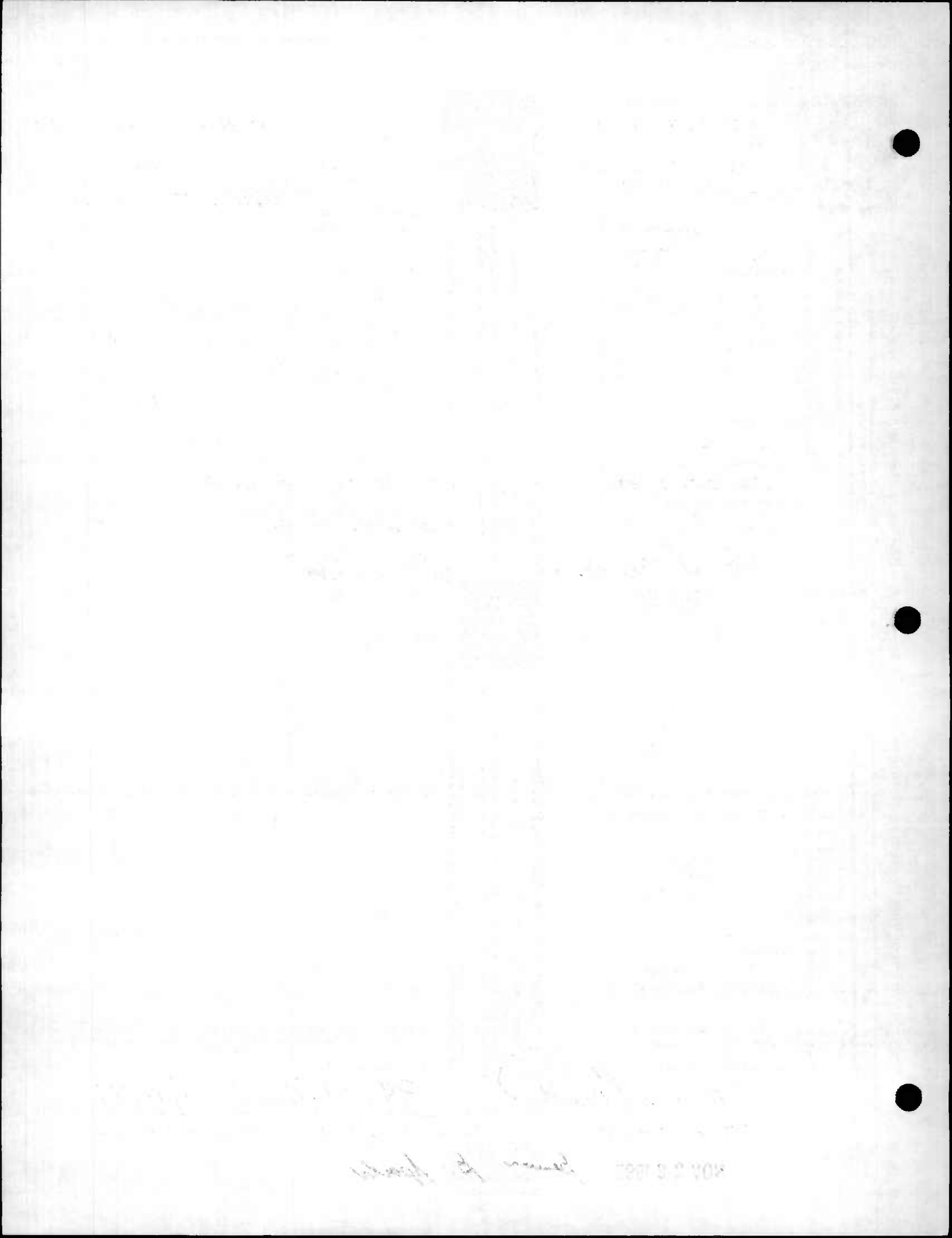
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38441

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES J. CAREY

2. Date of Death

Month

Day

Year

11 22 99

14 05P

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll County

Funeral
Director

5. Social Security Number

215-09-4824

6. Sex

10M 20F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 28, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Carroll County

10c. City, Town or Location

Taneytown

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

441 Red Tulip Court

10f. Zip Code

21787

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give Year or Dates:

1943-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

Specify: White

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

0

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

pipe fitter

16b. Kind of Business/Industry

Bethlehem Steel

Corporation

17. Father's Name (First, Middle, Last)

Frank S. Carey

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Stahlman

19a. Informant's Name/Relationship (Type, Print)

Sharon L. Sands / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

441 Red Tulip Court Taneytown, MD 21787

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

Nov. 26

1999

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

Alan C. Davis

22. Name and Address of Facility

Skiles Funeral Home
136 East Baltimore Street Taneytown, MD 21787

23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Due to (or as a consequence of):

b. Cardiogenic Shock

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24e. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 Outpatient

30 DOA

26. Place of Death (Check only one)

40 Nursing Home

50 Residence

80 Other (Specify)

27. Manner of Death

10 Natural

50 Pending investigation

20 Accident

60 Could not be determined

30 Suicide

40 Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hafeez A. Syed M.D.

29c. License number

D25052

29d. Date signed (Month, Day, Year)

11/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAFAEZ A SYED 20 Cross Roads Dr. Owings Mills 21117

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

X

James H. Jones

NOV 2 3 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38442

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|------------------------|---|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DONALD LEE CASON | | | | | | 2. Date of Death Month Day Year NOVEMBER 26 1999 | | | 3. Time of Death 1:00AM | |
| | 4a. Facility Name (If not institution, give street and number) 9504 OAKRIDGE COURT NEWBURG MD 20664 | | | | | | 4b. City, Town, or Location of Death NEWBURG MD | | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 229-52-2451 | | 6. Sex XX M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | | 8. Date of Birth (Month, Day, Year) August 23, 1942 | | 9. Birthplace (State or Foreign Country) Virginia | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Charles | | 10c. City, Town or Location Newburg | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 9504 Oak Ridge Court | | | | 10f. Zip Code 20664 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | | | 16b. Kind of Business/Industry Auto | | | |
| 17. Father's Name (First, Middle, Last) Ernest Raymond Cason | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nettie Woods Cason | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Darlene Norris/Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 76 Coltons Point, MD 20626 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Memory Gardens | | | Date 11/30/99 | | 20c. Location - City or Town, State Staunton, VA | | |
| 21. Signature of Funeral Service Licensee David C. Clark MO0945 | | | | | | 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD 20646 | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Lung CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier A. Patel | | | | 29c. License number D44436 | | 29d. Date signed (Month, Day, Year) November 26, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Patel, MD Preston Square #6B Industrial Park Dr Waldorf MD 20604 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 29 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38443

| | | | | | | | | |
|---|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) OSCAR ROBERT CANTER | | | | 2. Date of Death Month Day Year NOVEMBER 22, 1999 | | 3. Time of Death 6:05 PM | |
| | 4a. Facility Name (If not institution, give street and number) 17424 TEAGUES PT. ROAD | | | | 4b. City, Town, or Location of Death HUGHESVILLE | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 212-16-3278 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 19, 1919 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10. Usual Residence of Decedent 10e. State MARYLAND 10b. County CHARLES 10c. City, Town or Location HUGHESVILLE 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FARMER | |
| | 16b. Kind of Business/Industry AGRICULTURE | | 17. Father's Name (First, Middle, Last) ROBERT EDWARD CANTER | | 18. Mother's Name (First, Middle, Maiden Surname) NELLIE ERMA HUNTER | | 19a. Informant's Name/Relationship (Type, Print) BROTHER-THEODORE G. DAVIS, JR. -IN-LAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 SUNNYVIEW PLACE, NANJEMOY, MARYLAND 20662 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OLD FIELDS CHURCH CEM., NOV. 26, 1999, HUGHESVILLE, MD | | 20c. Location - City or Town, State | | 21. Signature of Funeral Service Licensee MARK G. BROHAWN M00053 | |
| | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. HYPOVOLUMIC SHOCK Due to (or as a consequence of): b. LOWER GASTROINTESTINAL BLEEDING Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death UNKNOWN | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| State Registrar | 29b. Signature and title of certifier Yahia M. Tagouri MD | | | | 29c. License number D0050883 | | 29d. Date signed (Month, Day, Year) NOVEMBER 23, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YAHIA M. TAGOURI, DME, 11655 WINESAP PLACE, LA PLATA, MARYLAND 20646 | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 29 1999 | | 32. Registrar's Signature Beverly B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38444**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Erma I. Dobrick

2. Date of Death

Month Day Year
November 28, 1999

3. Time of Death

9:24 A.M.

4a. Facility Name (If not institution, give street and number)

2938 Old Elk Neck Road

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

222-32-7256

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 6, 1906

9. Birthplace (State or Foreign Country)

Latvia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2938 Old Elk Neck Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In her own home

17. Father's Name (First, Middle, Last)

Adolph Berggrun

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Johnson

19a. Informant's Name/Relationship (Type, Print)

Bernice Moore / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2938 Old Elk Neck Road, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gracelawn Memorial Park

Date

December

20c. Location - City or Town, State

1, 1999 New Castle, Delaware

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Doherty Funeral Home

3200 Limestone Road, Wilmington, Delaware 19808

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urinary Tract Infection

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

044373

29d. Date signed (Month, Day, Year)

11/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph K. Weidner, Jr. MD, 101 Colonial Way, Rising Sun, Maryland 21911

31. Date filed (Month, Day, Year)

NOV 30 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38445

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE DIXON

2. Date of Death

November 21 1999

3. Time of Death

6:15 am

4a. Facility Name (If not institution, give street and number)

Copper Ridge

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

159-07-6533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 12 1907

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

710 Obrecht Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

bookkeeper

16b. Kind of Business/Industry

clerical

17. Father's Name (First, Middle, Last)

John McVey

18. Mother's Name (First, Middle, Maiden Surname)

Bessie

19a. Informant's Name/Relationship (Type, Print)

Nancy Kenehan (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6608 Christy Acres Ct., Mt. Airy, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Springfield Cemetery

Date

11-23-99

20c. Location - City or Town, State

Sykesville, Md

21. Signature of Funeral Service Licensee

► Paige Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Ernestine Wight, MD

29c. License number

D52740

29d. Date signed (Month, Day, Year)

November 22nd, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernestine Wight, Copper Ridge, 710 Obrecht Road, MD 21784

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

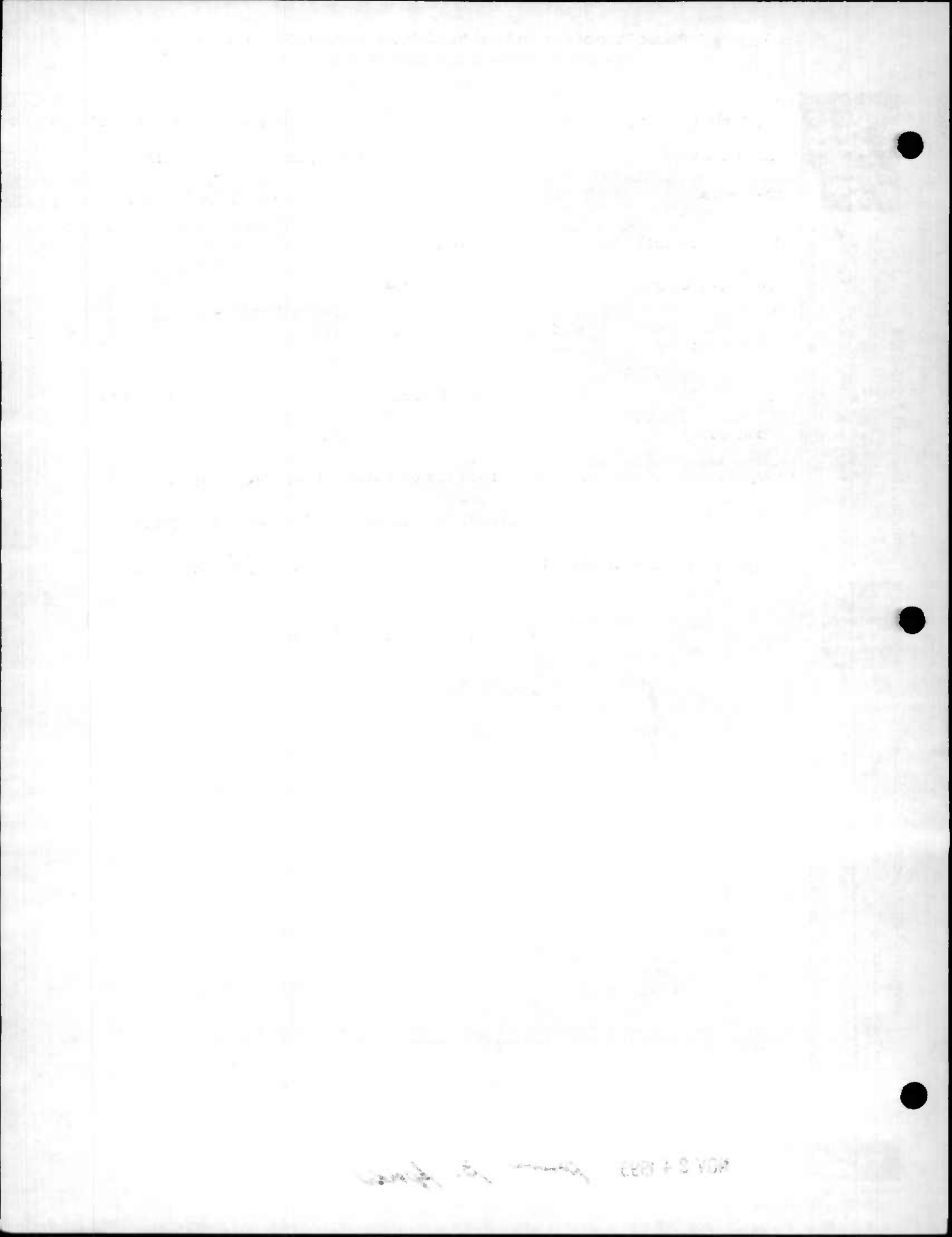
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Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38446

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Smith Gawthrop

2. Date of Death

Month Day Year
Nov 21, 1999

3. Time of Death

17:22

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

214-32-9239

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jul 13, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Penna

10b. County

Centre

10c. City, Town or Location

State College

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

645 Stoneledge Road

10f. Zip Code

16803

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Frederick Smith

18. Mother's Name (First, Middle, Maiden Surname)

Florence Wagner

19a. Informant's Name/Relationship (Type, Print)

Jean Shickman, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2518 Flagg Meadow Ct, Finksburg, MD 21048

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremations

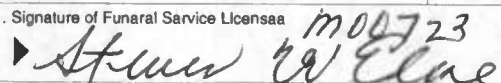
Date

11/23

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Eline Funeral Home

934 South Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Left Sided Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

b. Hypertension

Due to (or as a consequence of):

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

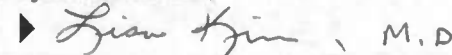
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D52479

29d. Date signed (Month, Day, Year)

November, 21, 1999


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LISA KIM, MD at Carroll County General Hospital, 200 Memorial Avenue, Westminster, MD 21157

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38447

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Henry Gamber Sr. | | | | 2. Date of Death Month Day Year Nov 19 1999 | | 3. Time of Death 12:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 4725 Babylon Road | | | | 4b. City, Town, or Location of Death Taneytown | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 213-28-0946 | 6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/> | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb 19 1931 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Carroll | 10c. City, Town or Location Taneytown | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 4725 Babylon Rd | | | 10f. Zip Code 21787 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 51-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Firefighter/Paramedic | | | 16b. Kind of Business/Industry Fire Department | | |
| | 17. Father's Name (First, Middle, Last) William T. Gamber | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Humple | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Lois D. Gamber/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4725 Babylon Rd. Taneytown, MD 21787 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | Date 11/26/99 | 20c. Location - City or Town, State Owings Mills, MD | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd. Westminster Md 21158 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. VENTRICULAR FIBRILLATION. Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death Instant 4 days |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Chitra Chedy Naganuma | | 29c. License number D18200 | | 29d. Date signed (Month, Day, Year) 11/22/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRA CHEDY NAGANUMA 700 Apple Rd Westminster MD 21157 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

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[Faint, mostly illegible text covering the majority of the page, appearing to be a letter or document.]

ROY & S. 1800
[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38448

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Ann Hayward

2. Date of Death

Nov 21 1999

Day Year

3. Time of Death

7:15pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Rehabilitation Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTgomery

Funeral
Director

5. Social Security Number

214-01-2500

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 24 1914

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Howard

10c. City, Town or Location

Glenelg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14950 Triadelphia Road

10f. Zip Code

21737

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

assembler

16b. Kind of Business/Industry

Bendix Corp.

17. Father's Name (First, Middle, Last)

Harry Swigert

18. Mother's Name (First, Middle, Maiden Surname)

Florence Seebo

19a. Informant's Name/Relationship (Type, Print)

Mildred Clark (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14950 Triadelphia Rd., Glenelg, MD 21737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crest Lawn Mausoleum

Date

11-23-99

20c. Location - City or Town, State

Marriottsville, Md

21. Signature of Funeral Service Licensee

P. Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 2178423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Urosepsis
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

24°

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

P. Haight Herbert

29c. License number

D41931

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

R Shumacher MD 2309 Shorefield Rd Wheaton, MD 20902

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
DHMH.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38449

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) MARY ELIZABETH HILL | | 2. Date of Death Month Day Year November 26, 1999 | | 3. Time of Death 7:50 AM | |
| 4a. Facility Name (If not institution, give street and number) 17101 Croom Road | | 4b. City, Town, or Location of Death Brandywine | | 4c. County of Death Prince George's | |
| 5. Social Security Number 040-18-3150 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 27, 1920 |
| 9. Birthplace (State or Foreign Country) Connecticut | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Brandywine | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 17101 Croom Road | | 10f. Zip Code 20613 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker | | 16b. Kind of Business/Industry Board of Education | |
| 17. Father's Name (First, Middle, Last) Roy C. Barker | | 18. Mother's Name (First, Middle, Maiden Surname) Belle Cornell Hutchinson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Vernon W. Hill/Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17101 Croom Road, Brandywine, Maryland 20613 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HUNTT CREMATORY | | 20c. Location - City or Town, State Nov. 27, 1999 WALDORF, MARYLAND | |
| 21. Signature of Funeral Service Licensee MARK G. BROHAWN MO0053 | | 22. Name and Address of Facility The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Md 20604 | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bilateral Breast Cancer | | | | | Approximate Interval Between Onset and Death 2 years |
| 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Harvey J. Katz | | 29c. License number 020352 | | 29d. Date signed (Month, Day, Year) 11-26-99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HARVEY J. KATZ, MD 8926 Woodward Rd Clinton, MS | | | | | |
| 31. Date filed (Month, Day, Year) NOV 29 1999 | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 1-800-368-7028.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38450

Dorothy J. Hensley
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last) DOROTHY JEAN HENSLEY | | | | | | 2. Date of Death Month Day Year Nov. 27, 1999 | | 3. Time of Death 12:50PM | |
| 4a. Facility Name (If not institution, give street and number) Civista Medical Center | | | | | 4b. City, Town, or Location of Death La Plata | | 4c. County of Death Charles | | |
| 5. Social Security Number 206-24-3671 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) SEPT. 22, 1932 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location HUGHESVILLE | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5989 SWANSON CREEK LANE | | | | 10f. Zip Code 20637 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL SECRETARY | | | 16b. Kind of Business/Industry HAMPTON TOWNSHIP SCHOOLS | | |
| 17. Father's Name (First, Middle, Last) JOHN COTTER | | | | | 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY ANGEL | | | | |
| 19a. Informant's Name/Relationship (Type, Print) CHRISTINE STEFANIDES DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY | | Date 12-1-99 | | 20c. Location - City or Town, State ALEXANDRIA, VA. | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Gastrointestinal Hemorrhage Due to (or as a consequence of): b. Disseminated intravascular coagulation Due to (or as a consequence of): c. Multi-organ failure Due to (or as a consequence of): d. Systemic Vasculitis | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D-33426 | | 29d. Date signed (Month, Day, Year) 11/28/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Larry Jenkins, MD 111 LaGrange Ave. P.O. Box 1724 La Plata, Maryland 20646 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 29 1999 | | | | 32. Registrar's Signature  | | | | | |

Certificate of Death

Reg. No.

Amended Item#23a perPhyG781 3/10/2000 FW

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Catherine Lee Myrle Iglehart

2. Date of Death

November 20, 1999
November 19, 1999

3. Time of Death

3:45 AM

4a. Facility Name (If not institution, give street and number)

Carroll County General hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

217-28-7097

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 26, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6031 Oakland Mills Road

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Theodore Reed Hooper

18. Mother's Name (First, Middle, Maiden Surname)

V. Myrle Green

19a. Informant's Name/Relationship (Type, Print)

Mr. Isaac M. Iglehart (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2151 Bollinger Mill Road Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park

Date

11/23/99 Sykesville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Brian L. Hays

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (PO Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

VENTRICULAR FIBRILLATION PROBABLY DUE TO ACUTE MYOCARDIAL ISCHEMIA

Immediate Cause (Final disease or condition resulting in death)

a. ~~New Left Occipital Cerebrovascular Infarct~~

Due to (or as a consequence of):

b. NEW LEFT OCCIPITAL CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

2 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lisa Kim, M.D.

29c. License number

D 52479

29d. Date signed (Month, Day, Year)

November, 20, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

LISA KIM, M.D., at Carroll County General Hospital, 200 Memorial Avenue, Westminster, MD 21159

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Handwritten signature or initials.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38452

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES HENRY JONES

2. Date of Death
Month Day Year
NOVEMBER 25, 19993. Time of Death
6:40 P.M.

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

579-38-5298

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV. 8, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

GENERAL DELIVERY

10f. Zip Code

20646

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1944-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TOWN GOVERNMENT

17. Father's Name (First, Middle, Last)

AUGUSTA JONES

18. Mother's Name (First, Middle, Maiden Summa)

ELIZABETH BARNES JONES

19a. Informant's Name/Relationship (Type, Print)

JAMES S. JONES / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3518 11TH STREET, N.W. WASHINGTON, D.C. 20010

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEMETERY

Date

12/3/99

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

b. Advanced Atherosclerosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

x 2 wks

x 1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-20629

29d. Date signed (Month, Day, Year)

11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE H. WATHEN, MD 11345 PIMBROOKE SQUARE, SUITE 103, WALDORF, MD 20603

State
Registrar

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitJames W Jones
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38453

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|--|---|---------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN FRANCIS KUPISCH | | 2. Date of Death Month 11 Day 22 Year 99 | | 3. Time of Death 0938 |
| | 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death Carroll |
| Funeral Director | 5. Social Security Number 216-30-1114 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Apr 22, 1932 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Monkton | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 1111 Monkton Road | | 10f. Zip Code 21111 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bridge Inspector | | 16b. Kind of Business/Industry Railroad | |
| 17. Father's Name (First, Middle, Last) John Peter Kupisch | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Marie Jendrek | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ann C. Packard, sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2126 Mayberry Rd, Westminster, MD 21158 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph Cath Cemetery | | 20c. Location - City or Town, State 11/26 Cockeysville, MD | |
| 21. Signature of Funeral Service Licensee Sharon W. Eline | | 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NON Q WAVE INFARCTION 3 DAYS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Hafeez A Syed MD | | 29c. License number D25052 | | 29d. Date signed (Month, Day, Year) 11/22/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAFAEZ A SYED 20 CROSSROADS DR MCLB 21117 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

NOV 2 4 1930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38454

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|---|---|--|---------------------------------|---|---|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD J. KLOTZ | | | | 2. Date of Death Month Day Year NOV. 21, 1999 | | | | 3. Time of Death 9:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 301 WEST MAIN ST. | | | | 4b. City, Town, or Location of Death WESTMINSTER | | | | 4c. County of Death CARROLL | | |
| Funeral Director | 5. Social Security Number 185-14-9210 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 11, 1922 | | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County CARROLL | | 10c. City, Town or Location WESTMINSTER | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 301 WEST MAIN ST. | | | | 10f. Zip Code 21158 | | 10g. Citizen of What Country? USA. | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | | 16b. Kind of Business/Industry HARDWARE STORE | | | |
| | 17. Father's Name (First, Middle, Last) BENJAMINE KLOTZ | | | | 18. Mother's Name (First, Middle, Maiden Surname) KATHRYN POCSCHIEVA | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) HELEN KLOTZ - WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 WEST MAIN ST., WESTMINSTER, MD. 21158 | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | Date 11/22/99 | | 20c. Location - City or Town, State BALTIMORE, MD. | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. Respiratory arrest Due to (or as a consequence of): b. Metastatic disease Due to (or as a consequence of): c. Cancer of distal esophagus Due to (or as a consequence of): d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 041725 | | | | 29d. Date signed (Month, Day, Year) 11/22/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARON Y. ALONGE MD 3000 GAMBER RD., SUITE 300, FINKSBURG, MD. 21048 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature or initials.

NOV 2 4 1908

Kenneth Landau

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38455
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth John Landau

2. Date of Death

November 26 1999

3. Time of Death

0045

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

069-14-9158

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 11, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

75 Cambridge Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Philip Landau

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Hunt

19a. Informant's Name/Relationship (Type, Print)

Dorothy E. Clark/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

75 Cambridge Road, Elkton, Maryland 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris & Co., Inc. 11/29/99 West Chester, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 W. Stockton St., Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Hours

b. Coronary Artery Disease
Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ OOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

00047711

29d. Date signed (Month, Day, Year)

November 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID GAR-EL 3 MAULDIN AVENUE NORTH EAST MARYLAND 21901

State
Registrar

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38456

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ella May Levredge

2. Date of Death

November 27 1999

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

793 Bouchelle Road

4b. City, Town, or Location of Death

North East

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

215-30-5513

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 8, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

793 Bouchelle Road

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In her own home

17. Father's Name (First, Middle, Last)

Cloud England

18. Mother's Name (First, Middle, Maiden Surname)

Flora May Mason

19a. Informant's Name/Relationship (Type, Print)

Fay Weaver/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 295, North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

December 1, 1999

20c. Location - City or Town, State

Elkton, Maryland

21. Signature of Funeral Service Licensee

Frederick S. Zellman II

22. Name and Address of Facility

Crouch Funeral Home
127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular disease
Due to (or as a consequence of):

b. Coronary artery disease
Due to (or as a consequence of):

c. Seizure disorder
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frederick S. Zellman II M.D.

29c. License number

044716

29d. Date signed (Month, Day, Year)

November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 West High St Elkton MD 21921

31. Date filed (Month, Day, Year)

NOV 30 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.
I am sorry to hear that you are having trouble with the machine.
I will try to get it fixed as soon as possible.
Very truly yours,
J. M. Smith

J. M. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38457

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|--|--|--|---|----|---------------|--|----|----------------------|----|--------------------------|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Beulah Marie Lowe</u> | | | | 2. Date of Death Month <u>November</u> Day <u>27</u> Year <u>1999</u> | | 3. Time of Death <u>4:40 PM</u> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) <u>142 Colora Rd.</u> | | | | 4b. City, Town, or Location of Death <u>Colora</u> | | 4c. County of Death <u>Cecil</u> | | | | | | | | | | |
| Funeral Director | 5. Social Security Number <u>235-30-7838</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>75</u> Yrs. | If Under 1 Year Months <u> </u> Days <u> </u> | If Under 24 Hrs. Hours <u> </u> Min. <u> </u> | 8. Date of Birth (Month, Day, Year) <u>Jan. 24, 1924</u> | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) <u>West Virginia</u> | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>Maryland</u> | | 10b. County <u>Cecil</u> | | 10c. City, Town or Location <u>Colora</u> | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| | 10e. Street and Number <u>142 Colora Rd.</u> | | | | 10f. Zip Code <u>21917</u> | | 10g. Citizen of What Country? <u>USA</u> | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u> </u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u> | | 16b. Kind of Business/Industry <u>Own Home</u> | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) <u>George D. Johnson</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Frances V. Riley</u> | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Clifford W. Lowe/Husband</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>142 Colora Rd. Colora, MD 21917</u> | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Bel Air Memorial Gardens</u> | | Date <u>11-30-99</u> | | 20c. Location - City or Town, State <u>Bel Air, Maryland</u> | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <u>Richard L. Joedie</u> | | 22. Name and Address of Facility <u>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</u> | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><u>Uremia</u></td> <td rowspan="4"> Approximate Interval Between Onset and Death <u>2 wks</u> <u>1 yr</u> <u>20 yrs</u> </td> </tr> <tr> <td>b.</td> <td><u>Renal Failure</u></td> </tr> <tr> <td>c.</td> <td><u>Diabetes Mellitus</u></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <u>Uremia</u> | Approximate Interval Between Onset and Death <u>2 wks</u> <u>1 yr</u> <u>20 yrs</u> | b. | <u>Renal Failure</u> | c. | <u>Diabetes Mellitus</u> | d. |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <u>Uremia</u> | Approximate Interval Between Onset and Death <u>2 wks</u> <u>1 yr</u> <u>20 yrs</u> | | | | | | | | | | | | | | |
| | b. | <u>Renal Failure</u> | | | | | | | | | | | | | | | |
| | c. | <u>Diabetes Mellitus</u> | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Artery disease</u> <u>Hypertension</u> <u>Peripheral Vascular Disease</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M <u> </u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <u>Hyung Lim MD</u> | | 29c. License number <u>D 46907</u> | | 29d. Date signed (Month, Day, Year) <u>11, 29, 1999</u> | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Hyung Lim 615 W. Macphail Rd, Bel Air MD 21014</u> | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>NOV 30 1999</u> | | 32. Registrar's Signature <u>B. Sparks</u> | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Certificate of Death


Reg. No.

99 38458

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) WILLIAM CHARLES LANDY | | | | 2. Date of Death Month Nov Day 22 Year 99 | | 3. Time of Death 12 PM | |
| 4a. Facility Name (If not institution, give street and number) CARROLL LUTHERAN VILLAGE HEALTH CARE | | | | 4b. City, Town, or Location of Death WESTMINSTER | | 4c. County of Death CARROLL | |
| 5. Social Security Number 146-14-3173 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/26/1919 | |
| 9. Birthplace (State or Foreign Country) NEW JERSEY | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County CARROLL | | 10c. City, Town or Location WESTMINSTER | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 724 POOLE RD. | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? USA. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DENTIST | | 16b. Kind of Business/Industry HEALTH | |
| 17. Father's Name (First, Middle, Last) WILLIAM HENRY LANDY | | | | 18. Mother's Name (First, Middle, Maiden Surname) CLARA IRENE KEENER | | | |
| 19a. Informant's Name/Relationship (Type, Print) WILLIAM R. LANDY - SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 CLEAR RIDGE RD., LINWOOD, MD. 21764 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WESTMINSTER CEMETERY | | Date 11/24/99 | | 20c. Location - City or Town, State WESTMINSTER, MD. | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. <u>Aspiration pneumonia</u> Due to (or as a consequence of): | | Approximate Interval Between Onset and Death <u>1 wk.</u> | |
| b. _____ Due to (or as a consequence of): | | c. _____ Due to (or as a consequence of): | | | |
| d. _____ Due to (or as a consequence of): | | | | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
Alzheimer's Dementia
Chronic Urinary tract infection

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Pending investigation

☐ Accident

☐ Could not be determined

☐ Suicide

☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
☐ Yes ☐ No

28d. Describe how injury occurred

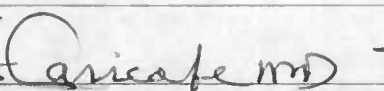
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D00906

29d. Date signed (Month, Day, Year)

11/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.H. CARICAPE M.D. P.O. Box 1110 Union Bridge MD 21791

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature



State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38459**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) KATHRYN LEWIS | | 2. Date of Death Month 11 Day 18 Year 99 | | 3. Time of Death 7AM | |
| 4a. Facility Name (If not institution, give street and number) 467 Johnsville Rd. | | | 4b. City, Town, or Location of Death Union Bridge | | 4c. County of Death Carroll |
| 5. Social Security Number 216-07-3654 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar. 25, 1907 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Union Bridge | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 467 Johnsville Rd. | | 10f. Zip Code 21791 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) stenographer | | 16b. Kind of Business/Industry drug company | | | |
| 17. Father's Name (First, Middle, Last) Marshall Senseney | | | 18. Mother's Name (First, Middle, Maiden Surname) Effie Repp | | |
| 19a. Informant's Name/Relationship (Type, Print) Marlin Hege/ caretaker | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 467 Johnsville Rd. Union Bridge, MD 21791 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Pipe Creek Cemetery | | 20c. Location - City or Town, State 11/22/99 nr. Linwood, MD | |
| 21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i> | | 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CVA Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death ID 8 yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. — | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Were encephalopathy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier <i>John Leigh</i> | | 29c. License number D20330 | | 29d. Date signed (Month, Day, Year) 11/18/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Leigh, 104 N. Main St., Union Bridge, MD | | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature <i>Barbara B. Sparks</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Handwritten text at the top of the page, possibly a header or title, including the word "Kontroll" and "Seite 1".

Main body of handwritten text, appearing to be a list or series of entries, though the handwriting is very faint and difficult to decipher.

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Handwritten text in the lower middle section, featuring several 'X' marks that may indicate specific items or status.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38460

AMENDED ITEM #18 PER FH G778 12/21/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM DAVID

2. Date of Death

Month

Day

Year

LEES November 25 1999 3:00 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

211-30-8396

6. Sex

M

7. Age (In yrs. last birthday)

59

8. Date of Birth (Month, Day, Year)

January 31, 1940

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8175 Plowden Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Senior VP of Operations

16b. Kind of Business/Industry

Hotel Management

17. Father's Name (First, Middle, Last)

George Downey Lees

18. Mother's Name (First, Middle, Maiden Surname)

JANE KOLB LEES

19a. Informant's Name/Relationship (Type, Print)

Carolyn Lees/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8175 Plowden Drive La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gar

Date

11/29/99

20c. Location - City or Town, State

Waldorf, MD

21. Signature of Funeral Service Licensee

AREHART-ECHOLS FUNERAL HOME, P.A.

22. Name and Address of Facility

P.O. BOX 567 LA PLATA MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Thyroid Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 years

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

INTERM

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

NOVEMBER 25, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

PHIL NIVATROMIN, 600 NORTH WOLFE STREET, NELSON 106, BALTIMORE, MD 21287-9106

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23c-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-516-1000.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|--|---|--|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Judy Lynn Moser | | | | 2. Date of Death Month Day Year NOVEMBER 19, 1999 | | 3. Time of Death 5:25 PM. | | | | |
| | 4a. Facility Name (If not institution, give street and number) 3100 SNYDESBURG RD. | | | | 4b. City, Town, or Location of Death SNYDESBURG | | 4c. County of Death Carroll | | | | |
| Funeral Director | 5. Social Security Number 220-80-9272 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth Month Day Year JAN 19 1961 | | 9. Birthplace (State or Foreign Country) PA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Westminster | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 529 Geneva Drive | | | | 10f. Zip Code 21157 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | | 16b. Kind of Business/Industry Carroll County Government | | | | |
| 17. Father's Name (First, Middle, Last) Claude H. Moser Sr | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Nusbaum | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Claude H. Moser Jr./brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 Geneva Drive Westminster, MD 21157 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Cemetery | | Date 11/23/99 | | 20c. Location - City or Town, State Sykesville, MD | | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 11-19-99 | | 28b. Time of Injury unknown M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject drowned self in pond | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Pond | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3100 Syndersburg Carroll County, Maryland | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Stephen S. Radentz, MD | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) NOVEMBER 20, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38462

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILFORD DOUGLAS MOORE

2. Date of Death

Month Day Year
NOVEMBER 25, 1999

3. Time of Death

2:52 AM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578-14-5457

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 10, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2944 OLD WASHINGTON ROAD

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TRUCK DRIVER & EQUIPMENT OP.

16b. Kind of Business/Industry

DISTRICT GOVERNMENT

17. Father's Name (First, Middle, Last)

SMITH MOORE

18. Mother's Name (First, Middle, Maiden Surname)

LAURA THOMPSON FOGGIE

19a. Informant's Name/Relationship (Type, Print)

ROSE M. MOORE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2944 OLD WASHINGTON ROAD, WALDORF, MARYLAND 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MARYLAND VETERAN CEMETERY

Date

12/1/99

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee

INDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

- a. *Acute Cardiopulmonary Arrest*
Due to (or as a consequence of):
- b. *Chronic Renal Failure*
Due to (or as a consequence of):
- c. *Septicemia*
Due to (or as a consequence of):
- d. *Hyperkalemia*

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D46374 (Md.)

29d. Date signed (Month, Day, Year)

NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony D. Thomas, M.D. 1328 Southern Ave, SE Washington DC

31. Date filed (Month, Day, Year)

11/27/99

32. Registrar's Signature

NOV 29 1999

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

99 38463

ORIGINAL


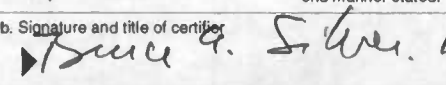
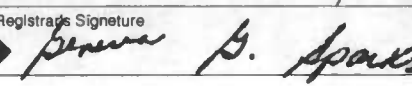
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

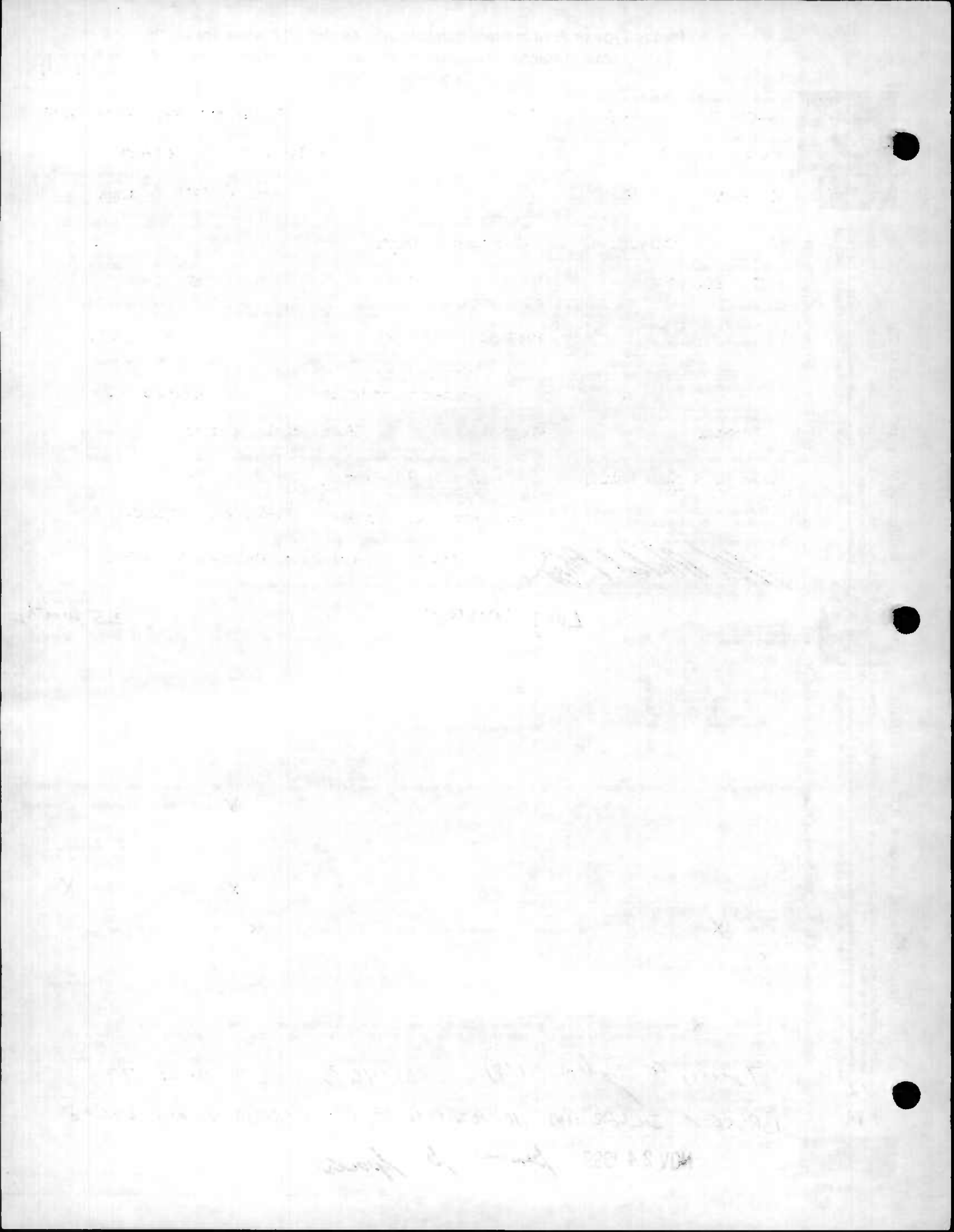
Reg. No.

99 38464

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Junior Wesley MORGAN | | | | | | 2. Date of Death Month November Day 22 , Year 1999 | | 3. Time of Death 4:15 am | | |
| | 4a. Facility Name (If not institution, give street and number) 8407 F Street | | | | | | 4b. City, Town, or Location of Death Chesapeake Beach | | 4c. County of Death Calvert | | |
| Funeral Director | 5. Social Security Number 485 12 9963 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 7, 1927 | | 9. Birthplace (State or Foreign Country) Iowa | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Calvert | | 10c. City, Town or Location Chesapeake Beach | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 8407 F Street | | | | 10f. Zip Code 20732 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 Collega (1-4or 5+) | | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boiler Technician | | | 16b. Kind of Business/Industry U.S. Gov't. | | | | |
| | 17. Father's Name (First, Middle, Last) Raymond Morgan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Veva Viola Patton | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Emma L. Morgan (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above | | | | | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Gardens | | Date 11-24-99 | | 20c. Location - City or Town, State Dunkirk, MD | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer | | | | | | | | Approximate Interval Between Onset and Death 25 months | | |
| | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | | | | | 29c. License number 021463 | | 29d. Date signed (Month, Day, Year) 11-22-99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BRUCE A. SILVER, MD 110 HOSPITAL RD, PRINCE FREDERICK, MD 20678 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature  | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38465

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHEROBA MABEL MARCHANT MACAULEY

2. Date of Death

Month Day Year
NOVEMBER 20 1999

3. Time of Death

6:15PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MANOR CARE

4b. City, Town, or Location of Death

LARGO

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-16-1446

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 4, 1908

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CALVERT

10c. City, Town or Location

OWINGS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7790 SWAN LANE

10f. Zip Code

20736

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

HUGH BLEVINS

18. Mother's Name (First, Middle, Maiden Summa)

MABEL THOMAS

19a. Informant's Name/Relationship (Type, Print)

GEORGE A. MARCHANT / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7790 SWAN LANE OWINGS, MARYLAND 20736

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SOUTHERN MEMORIAL GRDNS. 24, 1999 DUNKIRK, MARYLAND

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LEE FUNERAL HOME CALVERT, P.A.

8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

00055227

29d. Date signed (Month, Day, Year)

November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLORIA BURNS, M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

State
Registrar

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

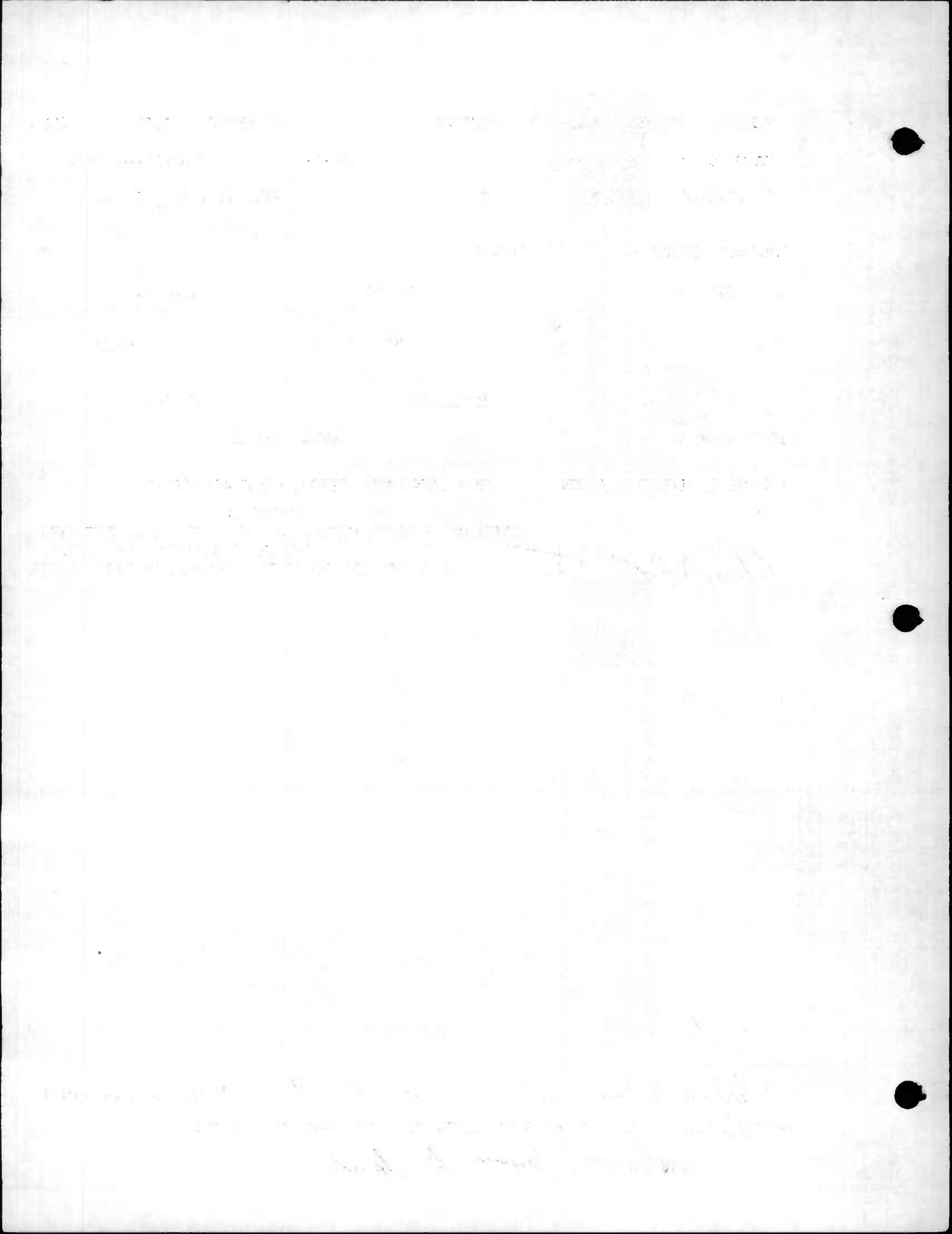
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelebile Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38466

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Margaret Lucille Maust

2. Date of Death

November 8, 1999

3. Time of Death

3:22 A.M.

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

210-05-5583

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 22, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 Kaylor Circle

10f. Zip Code

21532

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Faidley

18. Mother's Name (First, Middle, Maiden Summa)

Cora Maust

19a. Informant's Name/Relationship (Type, Print)

Linda M. Snyder/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13518 Old Cresaptown Rd., S.W., Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Cemetery, Nov 10, 1999

Date

20c. Location - City or Town, State

Salisbury, PA

21. Signature of Funeral Service Licensee

Ruth K. Neuman

22. Name and Address of Facility

Newman Funeral Homes, P.A., PO Box 275
179 Miller St., Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

11-7-99

Due to (or as a consequence of):

b. Intertrochanteric fracture of the left hip

11-2-99

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

Dementia

Angina

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No released

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

11-2-99

28b. Time of Injury

3:45 A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

Fell & injured left hip

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Frostburg Village Nursing Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Frostburg, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Renato S. Lapidario, M.D.

29c. License number

D9072

29d. Date signed (Month, Day, Year)

November 8, 1999

30. Name and address of person who completed cause of death (Item 28f) (Type, Print)

Renato S. Lapidario, M.D., 924 Seton Dr., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

NOV 8 9 1999

32. Registrar's Signature

Renato S. Lapidario

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO Certificate of Death

Reg. No.

99 38467

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Shamera Mann | | 2. Date of Death Month November Day 23 Year 1999 | | 3. Time of Death 07:35 AM. | |
| 4a. Facility Name (If not institution, give street and number) Peninsula Regional Hospital | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico |
| 5. Social Security Number 217-55-3043 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 4 | If Under 1 Year Months 4 Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 23, 1999 |
| 9. Birthplace (State or Foreign Country) MD | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Wicomico | 10c. City, Town or Location Salisbury | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 702 Booth St. | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S. |
| 11. Marital Status n/a <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: n/a | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n/a | | 16b. Kind of Business/Industry n/a |
| 17. Father's Name (First, Middle, Last) Bonzie Curtis | | | 18. Mother's Name (First, Middle, Maiden Surname) Shaneda Mann | | |
| 19a. Informant's Name/Relationship (Type, Print) Shaneda Mann/mother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Booth St., Salisbury, MD 21801 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Acres Mem Park | | Date 11/27/99 | 20c. Location - City or Town, State Salisbury, MD 21801 |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SUDDEN INFANT DEATH SYNDROME | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | |
| b. Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown N/A |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November 24, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chuteno 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 03 1999 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38468

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Orsino

2. Date of Death

November 28, 1999

3. Time of Death

1941

4a. Facility Name (If not Institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

051-16-2612

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1/22/1906

9. Birthplace (State or Foreign Country)

New York City, NY

Usual Residence of Decedent

10a. State

DE

10b. County

New Castle

10c. City, Town or Location

Newark

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 W. Regal Blvd.

10f. Zip Code

19713

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Aviation

17. Father's Name (First, Middle, Last)

Antonio Orsino

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Parente

19a. Informant's Name/Relationship (Type, Print)

Christine Kosiewicz-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 W. Regal Blvd., Newark, DE 19713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Saint's Cemetery

Date

12/3/99

20c. Location - City or Town, State

Wilmington, DE

21. Signature of Funeral Service Licensee

Frank C. Mayer, Jr.

22. Name and Address of Facility

Spicer Mullikin Funeral Home

1000 N. DuPont Hwy., New Castle, DE 19720

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Malnutrition

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Julie Poludniak

29c. License number

55315

29d. Date signed (Month, Day, Year)

November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julie Poludniak, MD - 322 E. Cecil Ave., North East, MD 21901

31. Date filed (Month, Day, Year)

NOV 30 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38469

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Bernard Prager

2. Date of Death

Month

Day

Year

11

19

1999

3. Time of Death

1315

4a. Facility Name (If not institution, give street and number)

Westminster Nursing & Convalescent Ctr.

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

217-22-5568

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 10, 1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

30 Locust St. Apt. 412

10f. Zip Code

21157

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1955-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Handyman

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

George John Prager

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Theresa Dunn

19a. Informant's Name/Relationship (Type, Print)

George A. Prager/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 317, Hampstead MD 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pipe Creek

Date

11/22/99

20c. Location - City or Town, State

Linwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

91 Willis Street
Myers Funeral Home Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pancreatic cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 min

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D254Y3

29d. Date signed (Month, Day, Year)

11/19/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

688 Bole Rd Westminster, MD 21157

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten signature

NOV 2 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38470

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|---|---|--|----------------------------------|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN POWELL | | | | 2. Date of Death Month Day Year November 20, 1999 | | 3. Time of Death 15:20 | |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death Prince Frederick Calvert | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 577 44 4899 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 65 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 16 1934 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Huntingtown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 5115 South Cabin Drive | | | | 10f. Zip Code 20639 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 53-56 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner /operator | | 16b. Kind of Business/Industry Pest Control | | |
| 17. Father's Name (First, Middle, Last) Linwood Powell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Florence Greene | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Deborah Seitz- daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 263 Pine Ridge Dr. Waveland Mississippi 39576 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service | | Date Nov 22, 1999 | | 20c. Location - City or Town, State Alexandria Virginia | | |
| 21. Signature of Funeral Service Licensee <i>B. Rausch</i> | | | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. rd. port Republic MD | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic coronary heart disease</i> Due to (or as a consequence of): b. <i>congestive heart failure</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease</i> | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Dr. Schlager</i> | | 29c. License number D16823 | | 29d. Date signed (Month, Day, Year) 11-22-1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Schlager, M.D. Prince Frederick, MD 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature <i>B. Sparks</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indellible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38471

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice D. Paradis

2. Date of Death

Month Day Year
November 17, 1999

3. Time of Death

8:25 am

4a. Facility Name (If not institution, give street and number)

Calvert County Nursing Center

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert County

Funeral
Director

5. Social Security Number

034 09 9922

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

101

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 14 1898

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Huntingtown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1280 Plum Point Road

10f. Zip Code

20639

10g. Citizen of What Country?

United States

11. Marital Status

☐ Navar Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

Notre Dame Cemetery

17. Father's Name (First, Middle, Last)

Louis Pierre Abraham Lemire

18. Mother's Name (First, Middle, Maiden Surname)

Amanda St. Martin

19a. Informant's Name/Relationship (Type, Print)

Robert E. Niedzielski- grandson same as #10

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Notre Dame Cemetery

Date

Nov 22, 1999

20c. Location - City or Town, State

Worcester Mass.

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Due to (or as a consequence of):

Myocardial Infarction

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicida ☐ Homicida

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s)
and manner stated.

29b. Signature and title of certifier

David Gallatin

29c. License number

D57949

29d. Date signed (Month, Day, Year)

11/17/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Gallatin, M.D. Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

NOV 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

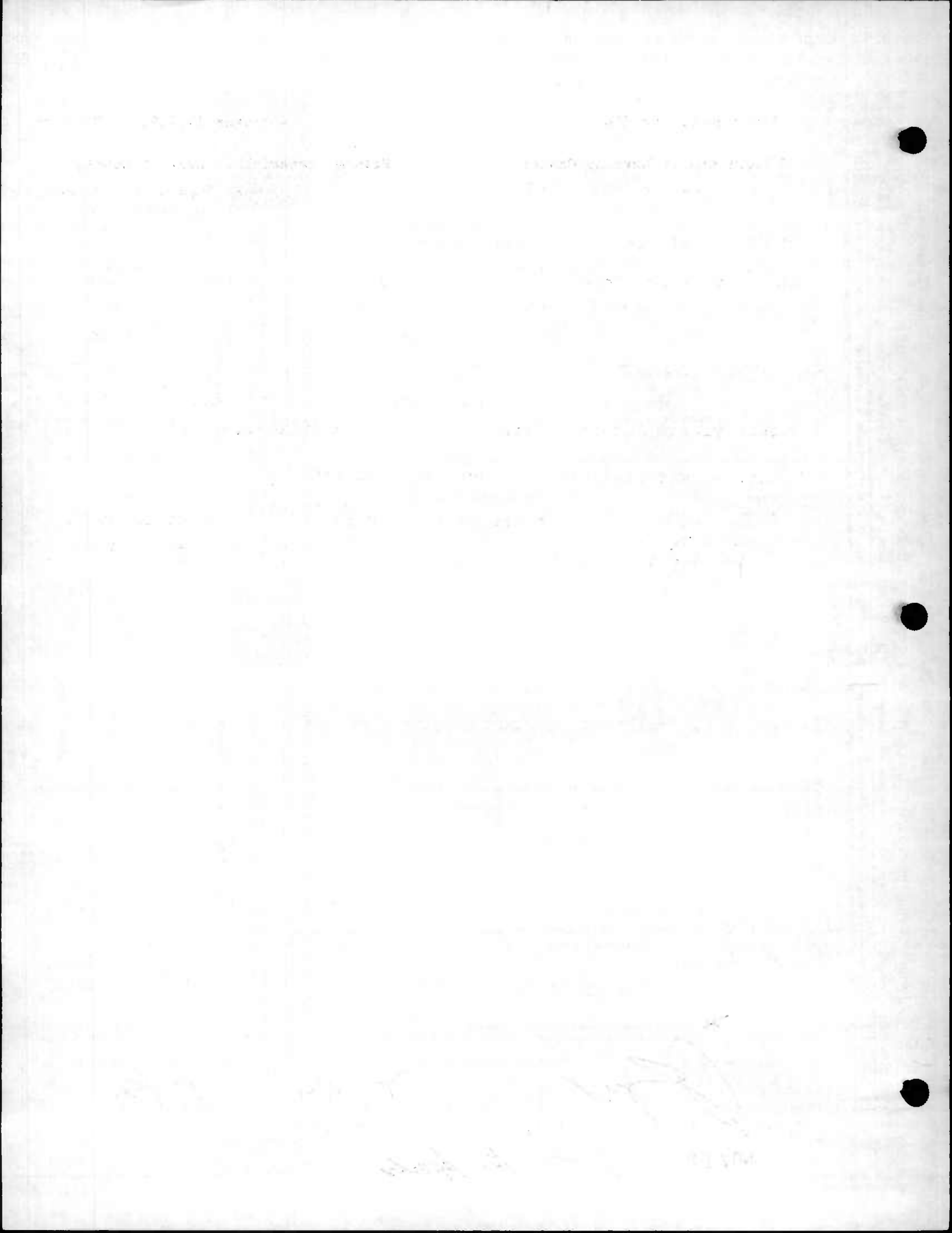
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38472

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedant's Name (First, Middle, Last)

JAMES ELWOOD QUEEN

2. Date of Death

November 27 1999

3. Time of Death

6:25 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Charles County Nursing Rehab Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

212-14-2591

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 16, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedant

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6160 Starview Place

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pipe Fitter

16b. Kind of Business/Industry

Power Plant

17. Father's Name (First, Middle, Last)

Thomas James Queen

18. Mother's Name (First, Middle, Maiden Surname)

Frances Elizabeth Lee Queen

19a. Informant's Name/Relationship (Type, Print)

Patricia Curtis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 2410 La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery 12/2/99 La Plata, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Elrod

M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.
P.O. BOX 567 LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lucio S. Villa

29c. License number

D0015513

29d. Date signed (Month, Day, Year)

11/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCIO S. VILLA - REAL, M.D., #10 ST. PATRICK'S DRIVE, #502, WINDSOR, MD 20603

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38473

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|-------------------------------|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles Vernon Richter | | | | 2. Date of Death Month Day Year Nov 17 1999 | | 3. Time of Death 8 PM | |
| | 4a. Facility Name (If not institution, give street and number) The Hermitage at St. John Creek | | | | 4b. City, Town, or Location of Death Solomons | | 4c. County of Death Calvert | |
| Funeral Director | 5. Social Security Number 215 18 7076 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 30, 1908 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Solomons | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 13325 Dowell Road | | | | 10f. Zip Code 20688 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Radio/ Electronics Tech | | | 16b. Kind of Business/Industry Communications | |
| 17. Father's Name (First, Middle, Last) William Richter | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Faul | | | |
| 19a. Informant's Name/Relationship (Type, Print) Betty Slingland- daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12970 Spring Cove Dr. Lusby Maryland 20657 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | | 20c. Location - City or Town, State Nov 20 1999 Baltimore Maryland | | |
| 21. Signature of Funeral Service Licensee B B Rausch | | | | | 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Aortic Stenosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 20676 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier David J. Tardio MD | | | 29c. License number D 47610 | | 29d. Date signed (Month, Day, Year) Nov 19 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Tardio, M.D. Prince Frederick, MD 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 19 1999 | | | 32. Registrar's Signature Benjamin B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text at the top of the page, mostly illegible.

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NOV 1 1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38474

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Christian Seiss

2. Date of Death

November 28, 1999

3. Time of Death

1710 P

4a. Facility Name (If not institution, give street and number)

476 Muddy Lane

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

161-05-3100

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

December 18, 1907

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

476 Muddy Lane

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1943-

If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

I

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Real Estate Business

17. Father's Name (First, Middle, Last)

William Cornelius Seiss

18. Mother's Name (First, Middle, Maiden Surname)

Mary Salome Helwig

19a. Informant's Name/Relationship (Type, Print)

William Seiss/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 314, Elkton, Maryland 21922

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Valley Forge Memorial

Gardens

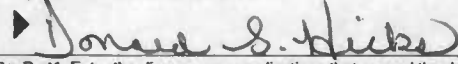
Date

12/2/99

20c. Location - City or Town, State

King of Prussia, PA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 W. Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Insufficiency

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

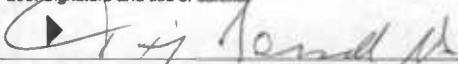
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33510

29d. Date signed (Month, Day, Year)

11-29-99

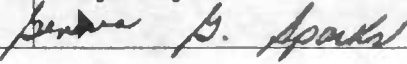
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 32 People Plaza GUNBOW DE 19702

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-328-2000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Adolf & family

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38475

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|----------------------|---|---|---|--------------------------------------|--|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Andrew Joseph Sullivan, III | | | | 2. Date of Death Month Day Year Nov. 19 1999 | | 3. Time of Death 2:28 PM | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 131 S. Tartan Drive-Buckhill Farms | | | | 4b. City, Town, or Location of Death Elkton | | 4c. County of Death Cecil | | | | | | | | |
| Funeral Director | 5. Social Security Number 196-36-8686 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) Sep 28 1945 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Elkton | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 131 S. Tartan Drive, Buckhill Farms | | | | 10f. Zip Code 21921 | | 10g. Citizen of What Country? USA | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler | | | 16b. Kind of Business/Industry Automobile | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Andrew Joseph Sullivan, II | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Terrezi | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lisa Maria Sullivan (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 S. Tartan Drive, Elkton, MD 21921 | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lawn Croft Cemetery | | Data 11/24/99 | | 20c. Location - City or Town, State Linwood, PA | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Chandler Funeral Home 2506 Concord Pike, Wilmington, DE 19803 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma Multiforme Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and Title of certifier  | | 29c. License number D0041418 | | 29d. Date signed (Month, Day, Year) 11/23/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Falchuck, MD, 4745 Ogletown-Stanton Rd, Ste 200, Newark, DE 19713 | | | | | | | | | | 31. Date filed (Month, Day, Year) NOV 30 1999 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38476

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOSEPHINE SHARKEY | | | | 2. Date of Death Month Day Year NOVEMBER 22, 1999 | | 3. Time of Death 03:50 | |
| | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death CITY | |
| Funeral Director | 5. Social Security Number 212-16-6140 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) 5/1/1916 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD. | | 10b. County CARROLL | | 10c. City, Town or Location WESTMINSTER | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 26 NEW WINDSOR RD. | | 10f. Zip Code 21158 | | 10g. Citizen of What Country? USA. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | 16b. Kind of Business/Industry RESTAURANT | | | | |
| 17. Father's Name (First, Middle, Last) JAMES CONSTANTINIDES | | | | 18. Mother's Name (First, Middle, Maiden Surname) VASILIKI GRAMATICOPOULOS | | | | |
| 19a. Informant's Name/Relationship (Type, Print) STANLEY L. SHARKEY -SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3164 FLICKINGER RD., WESTMINSTER, MD. 21158 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WESTMINSTER CEMETERY | | 20c. Location - City or Town, State 11/24/99 WESTMINSTER, MD. | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 10 DAYS | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, ATRIAL FIBRILLATION, DIABETES MELLITUS | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) NOVEMBER 22, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID WANG, MD, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE | | 31. Date filed (Month, Day, Year) NOV 24 1999 | | 32. Registrar's Signature  MARYLAND 21287 | | | | |

PH 10

Handwritten signature or initials

NOV 14 1933

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38477

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Cashman Strine

2. Date of Death
Month Day Year
November 21, 19993. Time of Death
23:00Funeral
Director

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

212-03-0536

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 8, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

New Windsor

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

310 Hillside Dr.

10f. Zip Code

21776

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Postmaster

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

John C. Strine

18. Mother's Name (First, Middle, Maiden Surname)

Viola Cashman

19a. Informant's Name/Relationship (Type, Print)

Mary B. Strine/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 Hillside Dr. New Windsor, MD 21776

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Pipe Creek Cemetery

Date

11/24/99 Linwood, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hartzler Funeral Home

310 Church St. New Windsor, MD 21776

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. cerebrovascular Accident

Approximate
Interval Between
Onset and Death

2 days

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Lisa Kim, M.D.

29c. License number

D 52479

29d. Date signed (Month, Day, Year)

November, 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LISA KIM, M.D. at Carroll County General
Hospital at 200 Memorial Avenue, Westminster, MD 21157

31. Date filed (Month, Day, Year)

NOV 23 1999

32. Registrar's Signature

B. Sparks

State
Registrar

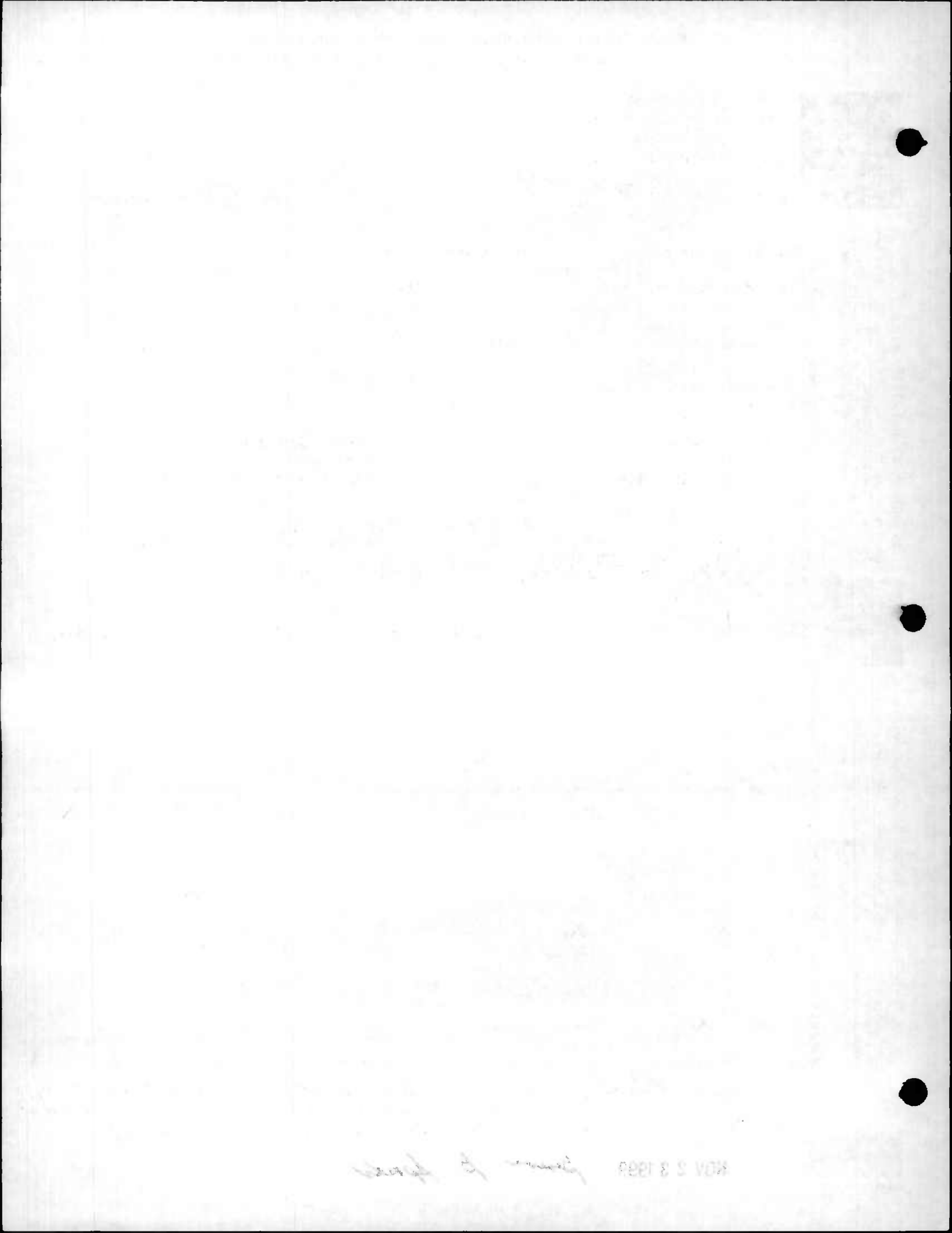
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38478

| | | | | | | | | | | | |
|---|---|---|--|---|---|--------------------------|--------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carrie Price SCRIBNER | | | | 2. Date of Death Month Day Year November 18, 1999 | | | | 3. Time of Death 7:40 pm | | |
| | 4a. Facility Name (If not institution, give street and number) Solomons Nursing Center | | | | 4b. City, Town, or Location of Death Solomons | | | | 4c. County of Death Calvert | | |
| Funeral Director | 5. Social Security Number 579 14 1583 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year) Aug. 1, 1919 | | 9. Birthplace (State or Foreign Country) MD | | 10a. State NJ | | 10b. County Lawrence | | 10c. City, Town or Location Lawrenceville | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State NJ | | 10b. County Lawrence | | 10c. City, Town or Location Lawrenceville | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 5 Merritt Drive | | | | 10f. Zip Code 08648 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) senior audit clerk | | | | 16b. Kind of Business/Industry retail sales | | | |
| 17. Father's Name (First, Middle, Last) Joseph Francis Gross | | | | 18. Mother's Name (First, Middle, Maiden Surname) Irene Edith Woodward | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary L. Wyckoff (daug.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190 Ponds Wood Rd., Huntingtown, MD 20639 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem. | | | | Date 11-22-99 | | 20c. Location - City or Town, State Suitland, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Rausch Funeral Home, Owings MD 20736 | | | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE MONTHS Due to (or as a consequence of): | | | | | | | | | | | |
| b. CORONARY ARTERY DISEASE MONTHS Due to (or as a consequence of): | | | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D40370 | | | | 29d. Date signed (Month, Day, Year) 11/20/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter L. Wisniewski, M.D. Prince Frederick, Md 20678 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 24 1999 | | | | 32. Registrar's Signature | | | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dawn M. Stephens AMEND ITEMS: 23 PART I, 28A-F PER MEO G77812/12 WR 38479

Reg. No.

Funeral Director

Physician / Medical Examiner

| | | | | | |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) DAWN MARIE STEPHENS | | 2. Date of Death Month November Day 18 Year 1999 | | 3. Time of Death 0644 | |
| 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince Georges |
| 5. Social Security Number 213-98-6057 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 34 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUNE 5, 1965 |
| 9. Birthplace (State or Foreign Country) WASHINGTON, D.C. | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MARYLAND | 10b. County CHARLES | 10c. City, Town or Location WALDORF | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2750 SCARLETT OAK COURT | | | 10f. Zip Code 20601 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REGISTERED NURSE | | 16b. Kind of Business/Industry MEDICAL (HOSPITAL) | | | |
| 17. Father's Name (First, Middle, Last) ROBERT MYRON JONES | | | 18. Mother's Name (First, Middle, Maiden Summa) GAYLE MARIE TRAVERS | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN M. STEPHENS/HUSBAND | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2750 SCARLETT OAK COURT, WALDORF, MARYLAND 20601 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) THE HUNTT CREMATORY | | 20c. Location - City or Town, State 11/22/1999 WALDORF, MARYLAND | |
| 21. Signature of Funeral Service Director JOHN P. KNISLEY | | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MIXED DRUG INTOXICATION | | | | | Approximate Interval Between Onset and Death |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found: 11-18-99 | | 28b. Time of Injury (Month, Day, Year) Found: 4:46 | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred SUBJECT TOOK DRUGS | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOUSE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5804 OLD BRANCH AVE. CAMP SPRINGS, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Dennis J. Chute | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) November , 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) NOV 22 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-584-1000.

To Be Completed by Funeral Director

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38480

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence M. Tarasca

2. Date of Death

Month

Day

Year

November

26

1999

3. Time of Death

11:56

4a. Facility Name (If not Institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

163-03-7756

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 6, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Charlestown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

316 Caroline Street

10f. Zip Code

21914

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In her own home

17. Father's Name (First, Middle, Last)

Salvato Martino

18. Mother's Name (First, Middle, Maiden Surname)

Florenner Volpe

19a. Informant's Name/Relationship (Type, Print)

Florence M. Whitney/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 228 Charlestown, Maryland 21914

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sts. Peter and Paul Cem.

Date

12/4/99

20c. Location - City or Town, State

Springfield, PA

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 W. Stockton St., Elkton, MD 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Goodill

29c. License number

D0037821 MD

29d. Date signed (Month, Day, Year)

11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Goodill 2600 Summit Bridge Rd. Suite 103 Newark, DE 19702

31. Date filed (Month, Day, Year)

NOV 29 1999

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1991-1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38481

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY A. TIPPETT

2. Date of Death

NOVEMBER 28, 1999 6:45AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

3810 OLD WASHINGTON ROAD

4b. City, Town, or Location of Death

WALDORF

4c. County of Death

CHARLES

5. Social Security Number

234-34-6647

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT 17 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3810 Old Washington Road

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ed Mullins

18. Mother's Name (First, Middle, Maiden Sumama)

Mary Belcher Mullins

19a. Informant's Name/Relationship (Type, Print)

Mary L. Rowe (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2627 Sun Valley Drive Waldorf, MD 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cem.

Date

11-30-99

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

Eberwein Funeral Services
4433 White Pls La White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

RENAL FAILURE

a. Due to (or as a consequence of):

CVA

b. Due to (or as a consequence of):

DIABETES

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M. Mathur

29c. License number

D28352

29d. Date signed (Month, Day, Year)

11-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD 20646

State
Registrar

31. Date filed (Month, Day, Year)

NOV 30 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38482

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stephania Purgar Tevlin

2. Date of Death

Nov. 22 1999

3. Time of Death

4:10pm

4a. Facility Name (If not institution, give street and number)

Fairhaven Health Center

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

070-30-7581

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 11 1908

9. Birthplace (State or Foreign Country)

Yugoslavia

Usual Residence of Decedent

10a. State

Md

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7200 Third Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

Joseph Purgar

18. Mother's Name (First, Middle, Maiden Surname)

Anna Lippert

19a. Informant's Name/Relationship (Type, Print)

Patricia DeCarlo (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1624 Tweed St., Rockville, Md 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

11-26-99

20c. Location - City or Town, State

Valhalla, NY

21. Signature of Funeral Service Licensee

B. Haight Herbert

22. Name and Address of Facility

Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Parkinson's disease with dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. P. M. MD

29c. License number

D34406

29d. Date signed (Month, Day, Year)

Nov 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richmond P. Allan, 1645 Liberty Rd., Eldersburg, MD 21784

State
Registrar

31. Date filed (Month, Day, Year)

NOV 24 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1941 - 1942

1943 - 1944

1945 - 1946

1947 - 1948

1949 - 1950

1951 - 1952

1953 - 1954

1955 - 1956

1957 - 1958

1959 - 1960

1961 - 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38483**
Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|---------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Etheline Thompson | | 2. Date of Death Month November Day 21 , Year 1999 | | 3. Time of Death 1200 |
| | 4a. Facility Name (If not institution, give street and number) Mariner Health of Greater Laurel | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George's |
| Funeral Director | 5. Social Security Number 169-34-3190 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) April 2, 1919 | | 9. Birthplace (State or Foreign Country) West Virginia | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Landover | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 1911 Barlowe Place | | 10f. Zip Code 20785 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | 16b. Kind of Business/Industry Board of Education | | |
| | 17. Father's Name (First, Middle, Last) Duley Tate | | 18. Mother's Name (First, Middle, Maiden Surname) Alberta Waters | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ellen Barnes/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Barlowe Place Landover, MD 20785 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Gardens | | 20c. Location - City or Town, State 11/26/99 Dunkirk, MD |
| | 21. Signature of Funeral Service Licensee Deborah G. Sewell | | 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non Hodgkins Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier Lyland B. Burns, M.D. | | 29c. License number D005522 7 | | 29d. Date signed (Month, Day, Year) November 22, 1999 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria A. Burns, MD 3001 Hospital Drive Cheverly, MD | | | | |
| 31. Date filed (Month, Day, Year) NOV 23 1999 | | 32. Registrar's Signature B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the new administration and the new Congress.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the new administration and the new Congress.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the new administration and the new Congress.

4. The fourth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the new administration and the new Congress.

5. The fifth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the new administration and the new Congress.

6. The sixth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains a great deal of information about the new administration and the new Congress.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38484

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT

Sylvester

TEANO, JR.

2. Date of Death

NOVEMBER 16, 1999

3. Time of Death

0526am

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Pr. Frederick

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

578-60-8115

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

12/7/46

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3725 Harbor Road

10f. Zip Code

20732

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

Vincent Sylvester Teano, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Elizabeth Waters

19a. Informant's Name/Relationship (Type, Print)

Dorothy Moore/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6402 Fisher Ct. Waldorf, MD 20603

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crem.


Date

11/17/99

20c. Location - City or Town, State

Alex., VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Raymond Funeral Home, PA

P.O. Box 121, Dunkirk, MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CIRROHSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

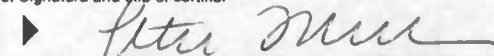
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D40370

29d. Date signed (Month, Day, Year)

11/16/99

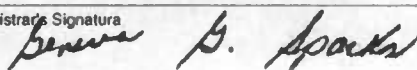
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER L. WISNIEWSKI, M.D., PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

NOV 18 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-534-2024.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NOV 21 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38485

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Cecilia Wineke

2. Date of Death

Month 11 Day 20 Year 99

3. Time of Death

1347

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

216-09-2546

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
Aug 17 1912

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

47 Old Hanover Road

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Department Manager

16b. Kind of Business/Industry

Food Fair

17. Father's Name (First, Middle, Last)

George Rutters

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Keffer

19a. Informant's Name/Relationship (Type, Print)

J. Michael Wineke/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2259 Old Taneytown Rd
Westminster, MD 21158

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Marys Cemetery

Date

11/24/99

20c. Location - City or Town, State

McSherrystown, PA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel
412 Washington Road Westminster, MD 21157

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra Cranial Bleeding
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Nasir MD

29c. License number

D35711

29d. Date signed (Month, Day, Year)

11/20/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mokhtar Nasir, 904 Washington Rd. Suite D, Westminster, MD, 21157

31. Date filed (Month, Day, Year)

NOV 22 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1944

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Nov 2 1944

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State of Maryland / Department of Health and Mental Hygiene

99 38486

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LORAINÉ LEWIS WAGNER | | | | 2. Date of Death Month Day Year NOVEMBER 24, 1999 | | | | 3. Time of Death 5:10 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 29754 MARSHALL ROAD | | | | 4b. City, Town, or Location of Death MECHANICSVILLE | | | | 4c. County of Death ST. MARY'S | | |
| Funeral Director | 5. Social Security Number 303-01-1816 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) DECEMBER 1, 1914 | | 9. Birthplace (State or Foreign Country) INDIANA | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location MECHANICSVILLE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10a. State MARYLAND | | 10b. County ST. MARY'S | | 10e. Street and Number 29754 MARSHALL ROAD | | | | 10f. Zip Code 20659 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | | | 16b. Kind of Business/Industry U. S. FEDERAL GOVERNMENT | | | |
| 17. Father's Name (First, Middle, Last) GILBERT E. LEWIS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) EVA D. MILLER | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JUDY W. AUTH/DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 392, HUGHESVILLE, MD 20637 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS | | | | 20c. Location - City or Town, State 11/29/1999 WALDORF, MARYLAND | | | |
| 21. Signature of Funeral Director JOHN P. KNISLEY | | | | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156 | | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer of unknown primary site with liver metastasis | | | | | | | | | | Approximate Interval Between Onset and Death 5 months | |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier Bruce A. Silver, MD | | | | 29c. License number D21463 | | | | 29d. Date signed (Month, Day, Year) 11-26-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bruce A. Silver, MD 110 Hospital Rd, Prince Frederick, MD 20678 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) NOV 29 1999 | | | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

JPK

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38487

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Boy White ANTONIO DESTIN WHITE

2. Date of Death

Month Day Year 12-03-99

3. Time of Death

8:10 am

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

NONE

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year) 38 12-03-99

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6320 Martin Luther King Highway

10f. Zip Code

20743

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

Antwaine Alexander Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Tammy Denise White

19a. Informant's Name/Relationship (Type, Print)

Tammy White / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6320 Martin Luther King Highway Seat Pleasant MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Release to hosp

20b. Place of Disposition (Name of cemetery, crematory or other place)

PGHC

Date

12-6-99

20c. Location - City or Town, State

Cheverly MD

21. Signature of Funeral Service Licensee

Joseph P. White

22. Name and Address of Facility

PGHC 3001 Hospital Drive Cheverly MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Extreme Prematurity (23 weeks gestation)

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

b.

c.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph P. White MD

29c. License number

D27628

29d. Date signed (Month, Day, Year)

12/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GELLET FRATTAROLA MD - 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

DEC 8 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38488

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Olive Nellie Arbogast

2. Date of Death

December 8 1999

3. Time of Death

2:35am

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-22-1717

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)
9/29/1914

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1309 Oakwood Road

10f. Zip Code

21061

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Smith

18. Mother's Name (First, Middle, Maiden Surname)

Ludania Bowers

19a. Informant's Name/Relationship (Type, Print)

Virginia Kathryn Ruark (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8211 WB & A Road Severn, MD 21144

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

12/10 1999

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Michael C. Jaffia

22. Name and Address of Facility

Singleton Funeral Home PA
1 Second Avenue S.W. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma Unknown Primary

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Diabetes Mellitus.

Due to (or as a consequence of):

d. Peripheral Vascular Disease.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shuan Elder MD House officer

29c. License number

D38993

29d. Date signed (Month, Day, Year)

12/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shuan Elder MD 2600 Liberty Hgts Baltimore MD 21215.

31. Date filed (Month, Day, Year)

DEC 09 1999

32. Registrar's Signature

B. Sparks

State Registrar

Metastatic melanoma (transferred from primary)

Highly metastatic

Prostate, Metastatic

Prostate, Metastatic

Prostate, Metastatic

Prostate, Metastatic

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38489

Amended Item#17 per FH 6778 12/9/99 EW

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ARI AVRAHAMI | | | | 2. Date of Death Month Day Year December 03, 1999 | | 3. Time of Death 7:28 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) University Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-90-0924 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12 8 1952 | 9. Birthplace (State or Foreign Country) ISRAEL | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 2930 MARNAT ROAD | | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER | | 16b. Kind of Business/Industry CELLULAR ELECTRONICS | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) NATHAN Natan AVRAHAMI | | | 18. Mother's Name (First, Middle, Maiden Surname) AUSNAT LEVY | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) NITZA AVRAHAMI/WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2930 MARNAT RD. BALTIMORE, MD. 21209 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) YAKON | | Date 12/6/99 | 20c. Location - City or Town, State TEL AVIV, GUSHDOM | | |
| | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to the Chest Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12-03-1999 | | 28b. Time of Injury 6:40 P M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred Subject was shot. | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking lot. | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 300 block of Tyson St., Baltimore, Maryland. | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 05, 1999 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 9 1999 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2-2-2000 WR.

AMEND ITEMS: # 23 PART I, 27 PER MEO G780

Certificate of Death

Reg. No.

99 38490

| | | | | | | | | | | | | | |
|---|---|--------------------------|---|---|---|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLORIA JEAN ALFONSO | | | | | | 2. Date of Death Month Day Year December 04, 1999 | | | 3. Time of Death 8:23 A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) 4217 Overton Avenue | | | | | | 4b. City, Town, or Location of Death Nottingham | | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 216-66-7216 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day, Year) May 16, 1953 | | 9. Birthplace (State or Foreign Country) Md. | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Nottingham | | | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 4217 Overton Avenue | | | | | | 10f. Zip Code 21236 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker | | | 16b. Kind of Business/Industry Own home | | | | |
| 17. Father's Name (First, Middle, Last) Henry Huffman Wine | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hilda Liddian Masson | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Martha Alfonso/daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 St. David Ct. Apt. X3 Cockeysville, Md. 21030 | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | Date 12/10/99 | | 20c. Location - City or Town, State Towson, Md. 21204 | | | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number O.C.M.E. | | | 29d. Date signed (Month, Day, Year) December 05, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE MCKAY 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 9 1999 | | | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

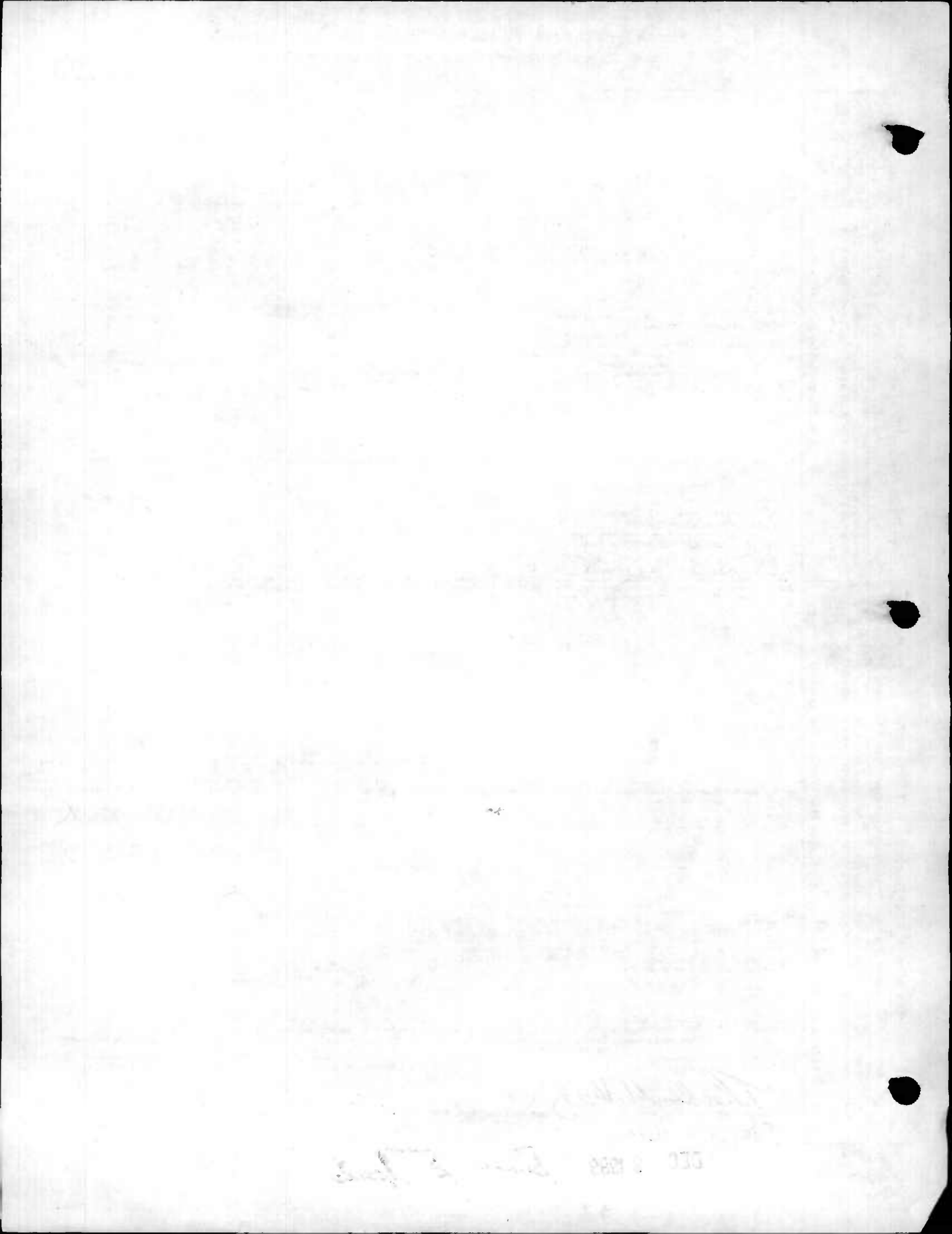
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 38491**

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) THOMAS ASHENFELTER | | | | 2. Date of Death Month December Day 8 Year 1999 | | 3. Time of Death 5:05am | | |
| | 4a. Facility Name (If not institution, give street and number) FAIRHAVEN | | | | 4b. City, Town, or Location of Death SYKESVILLE | | 4c. County of Death CARROLL | | |
| Funeral Director | 5. Social Security Number 212-01-7410 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 12, 1915 | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Sykesville | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 7200 Third Avenue | | | | 10f. Zip Code 21784 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technical Advisor | | 16b. Kind of Business/Industry Air Quality Management | | | | |
| | 17. Father's Name (First, Middle, Last) Howard Ashenfelter | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mabel Zeglin | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mrs. Ellen Wiser (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 Gillis Road Mt. Airy, MD 21771 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Serv. | | Date 12/9/99 | | 20c. Location - City or Town, State Sykesville, MD | | |
| | 21. Signature of Funeral Service Licensee Brian A. Wright | | | | 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of the oropharynx Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Ernestine Wright, MD | | 29c. License number DS2740 | | 29d. Date signed (Month, Day, Year) December 8th 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, FAIRHAVEN, SYKESVILLE MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DEC 8 1930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38492

| | | | | | | | | | |
|--|--|--|--|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD WILLIAM BIGLEY | | | | 2. Date of Death Month Day Year DECEMBER 6, 1999 | | 3. Time of Death 6:00am | | |
| | 4a. Facility Name (If not institution, give street and number) 710 NORTH HAMMONDS FERRY ROAD | | | | 4b. City, Town, or Location of Death LINTHICUM | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 215-09-9754 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) JULY 13, 1914 | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location LINTHICUM | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 710 NORTH HAMMONDS FERRY ROAD | | 10f. Zip Code 21090 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1942- If Yes, Give Year or Dates: 1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXAMINING ENGINEER | | 16b. Kind of Business/Industry AIRPORT | | | | | |
| 17. Father's Name (First, Middle, Last) WILLIAM BIGLEY | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA LITZ | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) HILDA ZACIERKA (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7751 NORTH POINT CREEK ROAD, BALTIMORE, MD. 21219 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | 20c. Date 12/10/99 | | 20d. Location - City or Town, State GLEN BURNIE, MD. | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u><i>hypertension</i></u> Due to (or as a consequence of): b. <u><i>stroke</i></u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u><i>Depression</i></u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier  MD | | | | 29c. License number D50812 | | 29d. Date signed (Month, Day, Year) 12/6/99 | | | |
| 30. Name and address of person who completes cause of death (Item 23a) (Type, Print) NICHOLAS MORTZOG, MD 6501 HUNTSWIRE, ELK LANE, MD 21075 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-528-0054.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

ADH
EUGENE BLACK
99-7353-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 38493

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EUGENE VINCENT BLACK, JR. | | | | 2. Date of Death Month Day Year DECEMBER 6, 1999 | | 3. Time of Death 1640 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number) REAR OF 5437 BELAIR ROAD | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | | | | |
| Funeral Director | 5. Social Security Number 213-68-3734 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) MARCH 13, 1958 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 3623 BREHMS LANE | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U. S. A. | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1977-1978 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 YEARS | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ROOFER | | | 16b. Kind of Business/Industry ROOFING | | | | |
| 17. Father's Name (First, Middle, Last) EUGENE L. BLACK SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) PATRICIA MAJCHRAK | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MRS. PATRICIA McCLUNG (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 GLANDEL CT., JOPPA MARYLAND 21085 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. STANISLAUS CEMETERY | | 20c. Date 12/10/99 | | 20d. Location - City or Town, State BALTIMORE, MARYLAND | | | | | |
| 21. Signature of Funeral Service Licensee Robert J. Rodachy | | | | 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Compressed Aphyxia and</u> Due to (or as a consequence of): <u>Multiple Injuries</u> Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? XXX Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 12/6/99 | | 28b. Time of Injury 1623 M | | 28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred victim crushed by bed of dump truck | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking lot | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5437 Belair Rd. | | | | | | | |
| 29a. Certifier (Check one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier L. A. L. L. L. | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) DECEMBER 7, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CARON WIFE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature B. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-3000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

0001 9 0 030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38494

AMEND#28a,b,c,d,f PER M.E.O. G778 12-9-99 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence R. Beardsley

2. Date of Death

Month Day Year

November 3, 1999

3. Time of Death

11:59 AM

4a. Facility Name (If not Institution, give street and number)

Grantsville Shopping Plaza Parking Lot

4b. City, Town, or Location of Death

Grantsville

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

191-01-5021

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 27, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Grantsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

198 Killdeer Lane

10f. Zip Code

21536

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jess A. Rhodes

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Stoner

19a. Informant's Name/Relationship (Type, Print)

Kathleen B. Johnson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

716 Broadmoor Lane, Annapolis, MD 21401

20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evergreen Cemetery, Nov 6, 1999

Date

20c. Location - City or Town, State

Point Marion, PA

21. Signature of Funeral Service Licensee

Ruth K. Newman

22. Name and Address of Facility

Newman Funeral Homes, P.A.

179 Miller St, POBox 275, Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Skull Fracture

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

seconds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

11-3-99

28b. Time of Injury

11:59

A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

HIT BY CAR

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Shopping plaza parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State)

GRANTSVILLE SHOPPING PARKING LOT

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Daniel Miller DO

29c. License number

H26154

29d. Date signed (Month, Day, Year)

11/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

69 Wolf Acres Drive Oakland MD 21550

31. Date filed (Month, Day, Year)

NOV - 5 1999

32. Registrar's Signature

A. Sparta

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2020.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A funeral certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental setup. It includes a list of the materials and equipment used, a description of the experimental procedure, and a discussion of the results. The results are presented in a series of tables and graphs, which show the relationship between the variables studied.

3. The third part of the report is a discussion of the results. It compares the results of the experiment with the results of previous studies and discusses the implications of the findings. It also mentions the limitations of the study and suggests areas for further research.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the conclusions drawn from the results. It also mentions the significance of the study and the contributions it has made to the field.

5. The fifth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study. It also includes a list of the people who have helped with the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 38495

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph A. Bova | | | | 2. Date of Death Month Day Year Dec 6 1999 | | 3. Time of Death 10:15 pm | | |
| | 4e. Facility Name (If not institution, give street and number) St. Elizabeth's Nursing and Rehab. Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 212-20-7462 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 99 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 17, 1900 | 9. Birthplace (State or Foreign Country) Ohio | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Worcester | | 10c. City, Town or Location Berlin | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 54 Anchor Way Drive | | | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cement Finisher | | 16b. Kind of Business/Industry City Government | | | |
| 17. Father's Name (First, Middle, Last) Peter Bova | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sebastiana Messineo | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary A. Topper/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Anchor Way Drive Berlin, Maryland 21811 | | | | | |
| 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Ceme. | | Date 12/10/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee Jackie H. Shannon | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia, right lung Due to (or as a consequence of): b. Acute pulmonary edema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 10 days 7 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease History of bladder cancer | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Benjamin S. Lee MD | | 29c. License number D52544 | | 29d. Date signed (Month, Day, Year) Dec. 7, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Benjamin S. Lee, MD, 700 Geipe Rd #204, Catonsville, MD 21228 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature Benjamin S. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

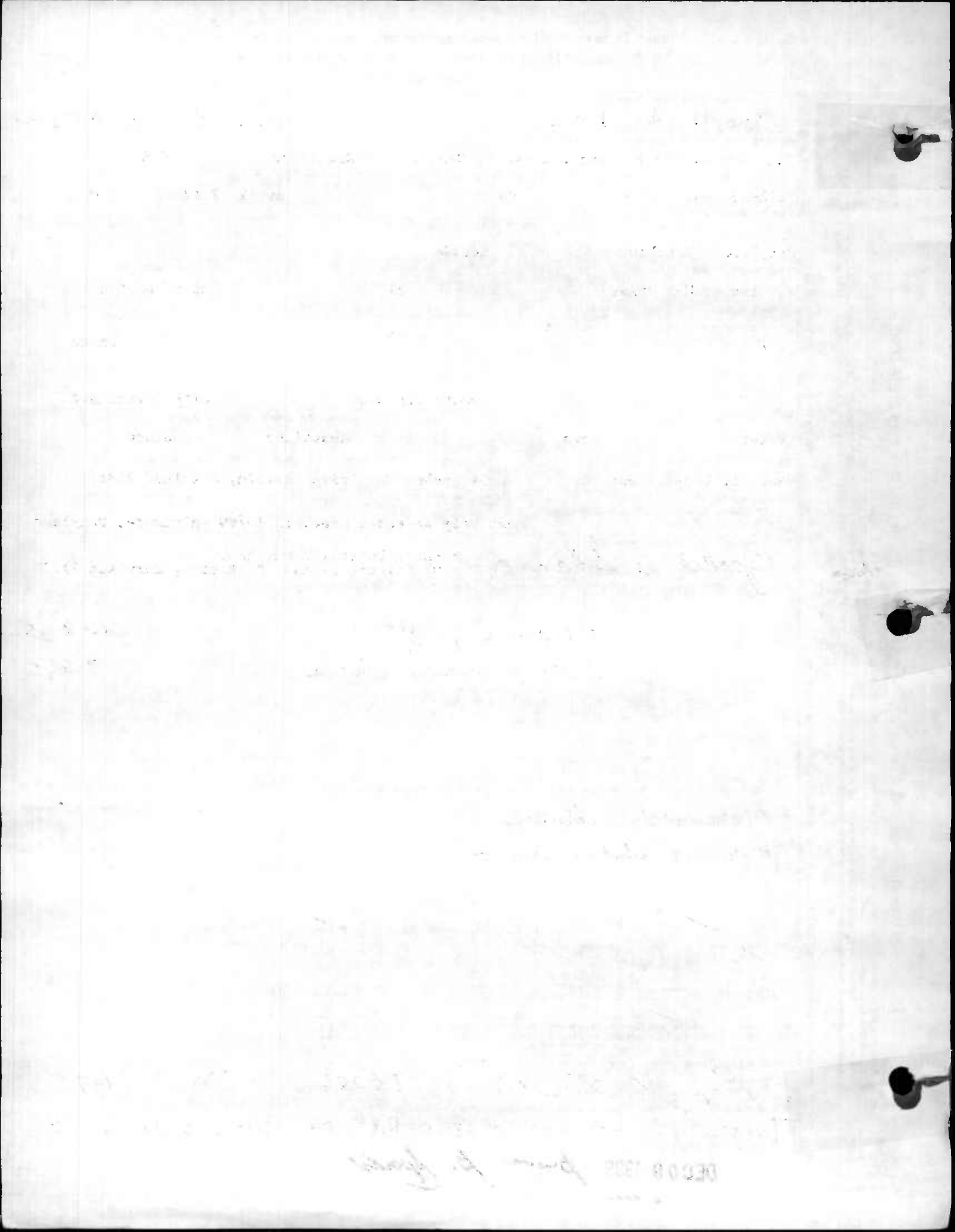
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38496

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|----------------------------------|---|--|--|---|--|---|----|----------------------------|----------------------------------|----------------|----|-----------------------------------|----------------------------------|-----------------|----|----------------------------------|----------------------------------|---------------|----|--------------------|----------------------------------|---------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Brandon Michael WEBB BROOKS | | | | 2. Date of Death Month 11 Day 29 Year 99 | | 3. Time of Death 1402 | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center | | | | 4b. City, Town, or Location of Death Baltimore, MD | | 4c. County of Death Baltimore City | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 215-55-5123 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) Yrs. 5 Months 28 | | 8. Date of Birth (Month, Day, Year) June 1, 1999 | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County City | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 316 S. Monroe Street | | | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE | | | 16b. Kind of Business/Industry NONE | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Michael A. BROoks | | | | 18. Mother's Name (First, Middle, Maiden Surname) Terri L. Webb | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Terri L. Webb (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 S. Monroe Street Baltimore, Maryland 21223 | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 12/1/99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Jackie D. Shannon | | | | 22. Name and Address of Facility HUBBARD Funeral Home 4107 Wilkens Avenue Baltimore, MD 21229 | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Respiratory Failure</td> <td>Due to (or as a consequence of):</td> <td>1 week.</td> </tr> <tr> <td>b.</td> <td>Multi system organ failure</td> <td>Due to (or as a consequence of):</td> <td>2.5 mths</td> </tr> <tr> <td>c.</td> <td>Necrotizing Enterocolitis</td> <td>Due to (or as a consequence of):</td> <td>4 mths</td> </tr> <tr> <td>d.</td> <td>Prematurity</td> <td>Due to (or as a consequence of):</td> <td>5 mths</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Respiratory Failure | Due to (or as a consequence of): | 1 week. | b. | Multi system organ failure | Due to (or as a consequence of): | 2.5 mths | c. | Necrotizing Enterocolitis | Due to (or as a consequence of): | 4 mths | d. | Prematurity | Due to (or as a consequence of): | 5 mths |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Respiratory Failure | Due to (or as a consequence of): | 1 week. | | | | | | | | | | | | | | | | | | | | | |
| | b. | Multi system organ failure | Due to (or as a consequence of): | 2.5 mths | | | | | | | | | | | | | | | | | | | | | |
| | c. | Necrotizing Enterocolitis | Due to (or as a consequence of): | 4 mths | | | | | | | | | | | | | | | | | | | | | |
| | d. | Prematurity | Due to (or as a consequence of): | 5 mths | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Roger W. Voigt M.D. | | | | 29c. License number D 42398 | | 29d. Date signed (Month, Day, Year) NOV. 29, 1999 | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roger W Voigt MD Pediatric Surgeon, UMMC, 22 S. Greene St, Baltimore MD 21201 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature Barbara B. Sparks | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-368-2343.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Barbara Mitchell 10/25/68
University of Maryland School of Medicine
Baltimore, MD

Respiratory Failure
Multi-system organ failure
Neurological abnormalities
Hemodynamic
2 min
1 week
2-3 min

Grade 1-2
D-4338
Grade 1-2
D-4338
Grade 1-2
D-4338

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

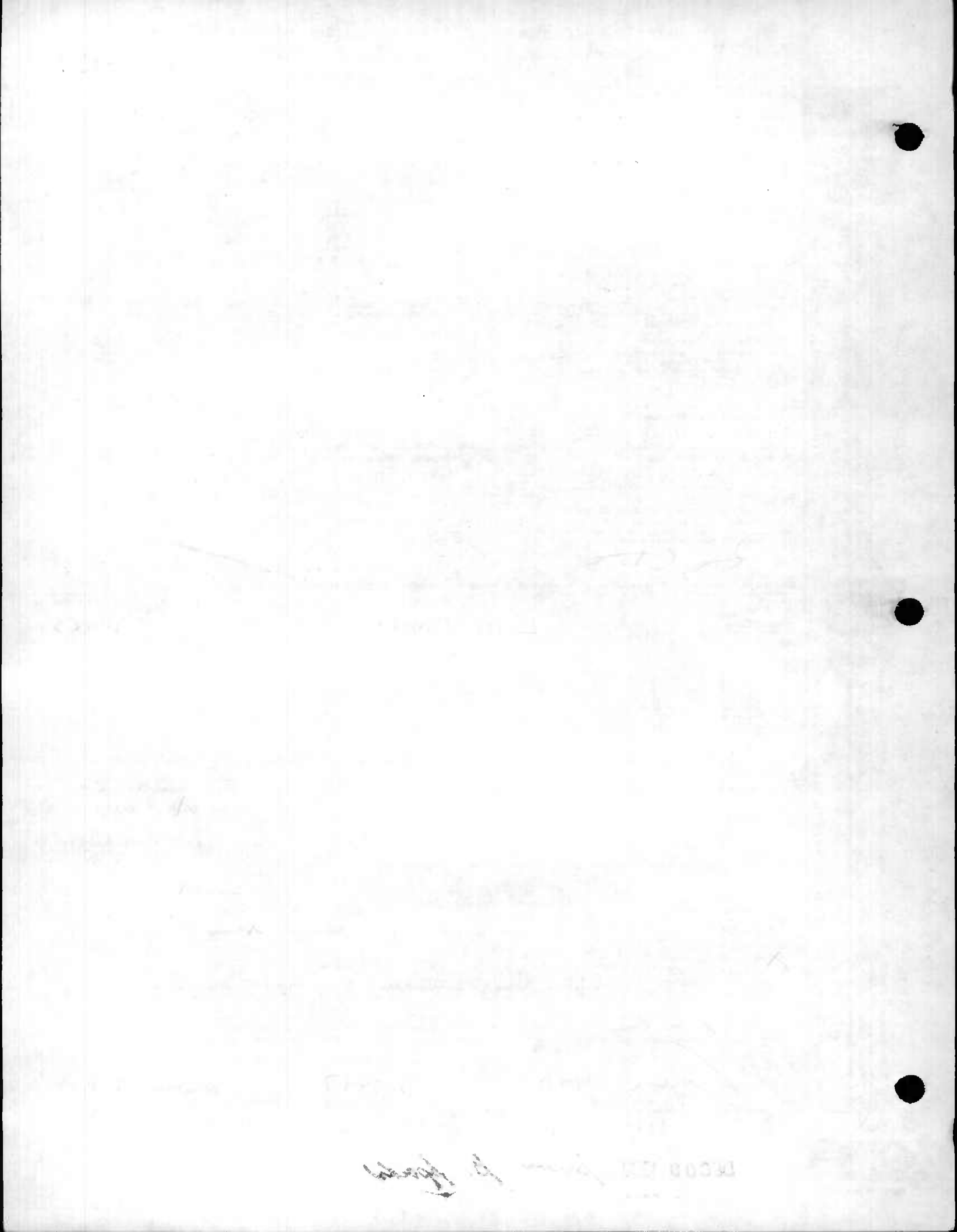
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38497

| | | | | | | | | |
|--|--|---|---|--|--|--|----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Julius Joseph Bobarsky | | | | 2. Date of Death Month Day Year Dec. 04 1999 | | 3. Time of Death 8:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) 707 Maiden Choice Lane | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 148-10-1715 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | 8. Date of Birth (Month, Day, Year) Apr. 12, 1914 | 9. Birthplace (State or Foreign Country) Pennsylvania | | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 707 Maiden Choice Lane | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | 16b. Kind of Business/Industry Postal Service | | |
| 17. Father's Name (First, Middle, Last) Michael O. Bobarsky | | | | 18. Mother's Name (First, Middle, Maiden Summe) Eva Potosky | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jane Frances Smith - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Eagle Ct. Grasonville, Maryland 21638 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Park | | Date 12/09/99 | | 20c. Location - City or Town, State Sykesville | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Maryland 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Liver Cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier MD | | | | 29c. License number D47447 | | 29d. Date signed (Month, Day, Year) December 7, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lazaris 711 Maiden Choice Lane Catonsville Md | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 38498

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN CHERRY CARR, SR. | | | | | | 2. Date of Death Month DEC. Day 2 Year 1999 | | 3. Time of Death 11:15 PM | | |
| | 4a. Facility Name (If not institution, give street and number) BON SECUR Hospital | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 21738 6002 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 18, 1943 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2821 Mayfield Ave | | | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipe Layer | | | 16b. Kind of Business/Industry Construction Company | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) JOHN Carr | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) LAURA Ann BYERS | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Pearlie Carr Luck | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 Southern Ave Baltimore, Md 21206 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Zion Cemetery | | Date 12-9-99 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee [Signature] | | | | | | 22. Name and Address of Facility CHATHAM - Home of the Elderly 5240 RIVERVIEW RD BALTIMORE, MD 21215 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SPONTANEOUS PNEUMOTHORAX Due to (or as a consequence of): b. BILATERAL PNEUMONITIS Due to (or as a consequence of): c. AUTOIMMUNE DEFICIENCY DISORDER Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTRO INTESTINAL BLEEDING THROMBOCYTOPENIA | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier [Signature] | | | | | | 29c. License number D0024100 | | 29d. Date signed (Month, Day, Year) 12-3-99 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADURA L. PRABHAKAR, M.D. 2115 OLD OUREM ROAD, BAL MD 21220 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 9 1999 | | | | | | | | | | | |
| 32. Registrar's Signature [Signature] | | | | | | | | | | | |

ORIGINAL

Special Agent in Charge
Bureau of Investigation
Washington, D. C.

TO THE DIRECTOR, FBI
FROM THE SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]
[Illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38499

Amended Item#1 perPHYG781 3/10/2000 EW

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILBERT ROBERT COLLINS

2. Date of Death

Month Day Year
11 24 1999

3. Time of Death

10:24 AM

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System E.D.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-38-0894

6. Sex

M 2 F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 18, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

10a. State

N/A

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1110 STODDARD COURT

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

WILBERT E. FORD

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Collins

19a. Informant's Name/Relationship (Type, Print)

ELAINA A. COLLINS Carter daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 HERRICK CT BALTIMORE, MD 21244

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR CEMETERY

Date

11/30/99

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee

Jenny Harris

22. Name and Address of Facility

OWATMAN - HARRIS Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth H. Butler

29c. License number

H46145

29d. Date signed (Month, Day, Year)

10-24-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH H. BUTLER UNIVERSITY OF MD. MEDICAL SYSTEM BALTIMORE. MARYLAND 21201

31. Date filed (Month, Day, Year)

DEC 9 1999

Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1884-1885

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 38500

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last) LUCILLE HACKER CAMPBELL | | 2. Date of Death Month Day Year DECEMBER 7, 1999 | | 3. Time of Death 2:40 PM | |
| 4a. Facility Name (If not institution, give street and number) CHARLESTOWN CARE CENTER | | | 4b. City, Town, or Location of Death CATONSVILLE | | 4c. County of Death BALTIMORE |
| 5. Social Security Number 705-09-1458 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | 8. Date of Birth (Month, Day, Year) 9/19/1907 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | |
| 10a. Street and Number 709 Maiden Choice Lane | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claim Investigator | | 16b. Kind of Business/Industry B&O Railroad | |
| 17. Father's Name (First, Middle, Last) Richard Hacker | | | 18. Mother's Name (First, Middle, Maiden Surname) Carry Eggleston | | |
| 19a. Informant's Name/Relationship (Type, Print) Jean Sanders Niece | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Connecticut Ave. NW Washington D.C. 20008 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation | | 20c. Location - City or Town, State Stevensville, MD | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death many years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and Title of certifier MD | | 29c. License number D47009 | | 29d. Date signed (Month, Day, Year) December 8, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip Stone, 711 Maiden Choice Lane, Catonsville, MD 21228 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1999 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

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Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

